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2016-17 Biennial Budget – Department of Human Services

http://www.mn.gov/dhs

AT A GLANCE

- Health care programs (Medical Assistance, Minnesota-Care) — 864,158 people on average enrolled per month in 2013
- Supplemental Nutrition Assistance Program (SNAP) — over 500,000 people received help each month in 2013
- Minnesota Family Investment Program and Diversionary Work Program — 40,000 families with low incomes assisted per month in 2013
- Child support — 398,000 custodial and noncustodial parents and their 270,000 children receive services
- Child care assistance — 31,219 children assisted in a month
- Adults receiving publicly funded mental health services — 51,916 people per month in 2013
- Children and youth receiving publicly funded mental health services — 22,647 per month in 2013
- DHS Direct Care and Treatment provided services to more than 12,000 individuals in fiscal year 2014
- FY 2013 all funds spending = $12.1 billion

PURPOSE

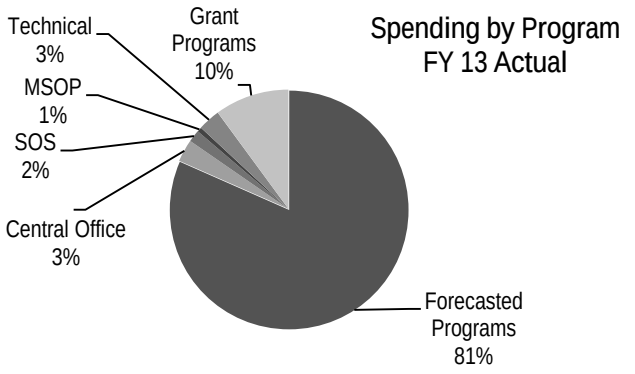
The Minnesota Department of Human Services (DHS), working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve and, ultimately, to all Minnesotans.

DHS contributes to the following statewide outcomes:

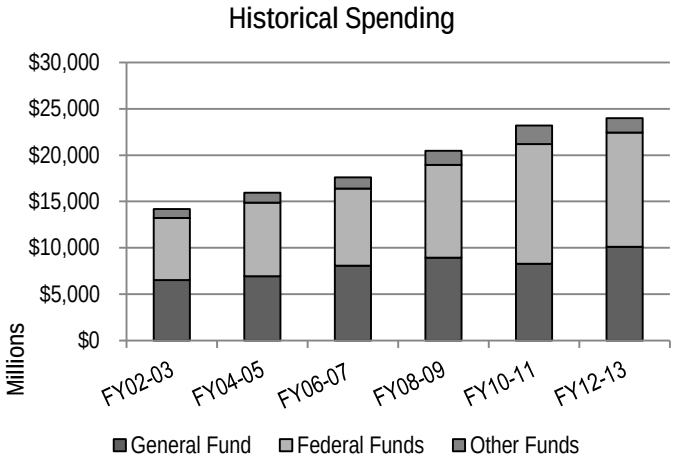
- All Minnesotans have optimal health.
- Strong and stable families and communities.
- People in Minnesota are safe.

BUDGET



Forecasted Programs includes: Medical Assistance 69%, MinnesotaCare 5%, Economic support programs 6%, and other health care programs 1 %.
MSOP = Minnesota Sex Offender Program; SOS = State-Operated Services

Source: SWIFT



Source: Consolidated Fund Statement

Minnesota has a strong tradition of providing human services for people in need so they can live as independently as possible, and of working to ensure that Minnesotans with disabilities are able to live, work and enjoy life in the most integrated setting desired. DHS provides oversight and direction for most health and human services programs, making sure providers meet service expectations. Most services are delivered directly to people by counties, tribes, health care providers or other community partners. Some DHS employees provide direct care and treatment to people with mental illness, chemical dependency and developmental disabilities as well as to individuals civilly committed for sex offender treatment.

Examples of our work include:

- Health care programs which purchase medical care and related home- and community-based services for children, seniors, people with disabilities and people with low incomes.
- Economic assistance programs which provide assistance to low-income Minnesotans to help them move toward greater independence.
- Services to children who have suffered abuse or neglect, to assure their safety and well-being, and early intervention services to children at-risk of abuse or neglect.
- Grant programs to support local delivery of human services for populations in need, including recent refugee immigrant populations, adults and children with mental illness or substance abuse problems, people who are deaf or hard of hearing, seniors and vulnerable adults.
- Direct care provided through a statewide array of institutional and community-based services. Services are targeted to people experiencing mental illness, chemical dependency, developmental disabilities and/or an acquired brain injury, some of whom are civilly committed by the court because they may pose a risk to themselves or others.
- Residential services and treatment to people who are committed by the court as a sexual psychopathic personality or a sexually dangerous person.

STRATEGIES

We emphasize several strategies across our budget activity and program areas to realize our mission and support the statewide outcomes listed above. We organize the strategies currently emphasized within DHS in four broad categories:

People: Provide smart care that keeps people healthy and in their homes and communities

- Improve access to affordable health care
- Better protect children and vulnerable adults in families and facilities, especially those directly in our care
- Keep more people fed and healthy by increasing nutrition assistance participation, especially for seniors
- Serve more people in their own homes, communities and integrated workplaces
- Reduce the rate of prenatal exposure to alcohol or drugs
- Enhance long-term care planning
- Integrate primary care, behavioral health and long-term care
- Implement a new autism benefit for children
- Increase access to prevention, outreach, shelter, and housing for at-risk and homeless youth
- Expand employee engagement efforts across the agency

Innovation: Redesign our care delivery systems

- Expand the number of providers and enrollees participating in Integrated Health Partnerships (Medicaid Accountable Care Organizations)
- Evaluate quality of life and care for people receiving services by using online report cards for home and community-based services and nursing facilities
- Decrease the amount of time it takes to determine disability status and eligibility for assistance
- Launch new Community First Services and Supports to support people in their communities
- Streamline the adult protection system
- Build new working partnerships and governance arrangements with counties and tribes to improve client services
- Modernize eligibility and enrollment systems

Equity: Increase equity and improve outcomes

- Lower the disproportionate number of children of color in out-of-home placements
- Decrease the number of children in foster care waiting for adoption
- Reduce the gap in access and outcomes for health care in cultural and ethnic communities
- Increase the number of children in underserved communities enrolled in quality child care settings
- Hold managed care plans accountable for health equity outcomes related to depression, diabetes and well child visits

Integrity: Reduce fraud, waste and abuse

- Reduce Supplemental Nutrition Assistance Program error rate
- Develop more accurate and efficient background study process
- Increase fraud investigations of Child Care Assistance providers
- Implement new regulatory oversight to support people living safely in homes and communities
- Implement onsite enrollment screening requirements for medium- and high-risk providers
- Expand provider investigations through Recovery Act contracts

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The Department of Human Services' overall legal authority comes from Minnesota Statutes chapters 245 (https://www.revisor.mn.gov/statutes?id=245) and 256. (https://www.revisor.mn.gov/statutes/?id=256) We list additional program-specific legal authority at the end of each budget activity narrative.

Program: Central Office Operations
Activity: Operations

AT A GLANCE

- Provides human resource management for about 6,500 state staff and about 3,600 county staff
- Licenses more than 23,000 service providers
- Conducts over 275,000 background studies annually on staff working with vulnerable adults and children
- Conducts more than 16,156 recipient fraud investigations resulting in over $5.4 million in recoveries.
- Conducts more than 330 provider fraud investigations annually resulting in overpayment recoveries totaling more than $4.5 million
- Annually investigates 950 maltreatment allegations
- Conducts more than 10,876 administrative fair hearings per year
- Reviews and approves more than 2,100 contracts per year
- Funding for human services computer systems (which are the responsibility of MN.IT @ DHS) flows through this Operations activity. In FY 2013 spending for those computer systems was $151.7 million. That represents 1.3% of the Department of Human Services overall budget.
- All funds spending for non-IT Operations activity for FY 2013 was $52.1 million. This represents another 0.4% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The Operations area within the Department of Human Services (DHS) serves external customers, internal staff, and ensures integrity of public money. To outside customers, we license service providers and conduct background studies – key activities that keep Minnesotans safe and protect our most vulnerable citizens. For our external customers, we also provide appeals processes, tribal, county, and community relations, and communication resources.

To internal staff, we provide human resources services, financial management, legal services, and facilities management.

Finally, we work to ensure the prudent use of public dollars by investigating, preventing, and stopping fraudulent uses of state and federal money.

SERVICES PROVIDED

Our *Human Resources Division* provides human resources management services for staff at the agency and for approximately 3,600 county human services employees. This division provides staffing, health, safety, compensation, job classification, labor relations, management consulting, benefits administration, workers compensation and employee assistance services to managers and employees. The division is also responsible for the agency's Continuous Improvements training and initiatives, and for recycling, facilities management, mail processing, security, information desk services, and vehicle management.

The DHS Office of Inspector General manages financial fraud and abuse investigations; licenses programs such as family child care, adult foster care, and mental health centers; and conducts background studies on people who apply to work in these settings

Our Licensing Division licenses residential and nonresidential programs for children and vulnerable adults to ensure that the programs meet the requirements and the law. These programs include child care centers, family child care (via counties), foster care, adoption agencies, and services for people with developmental disabilities, chemical dependency, and mental illness. Our staff also completes investigations of maltreatment of clients.

Our Background Studies Division annually conducts over 275,000 background studies on people working with children or vulnerable adults.

Our Fraud Investigations Division oversees fraud prevention and financial recovery efforts in health care, economic assistance, child care assistance, and food support programs.

Our Office of Indian Policy provides guidance in the implementation and coordination of ongoing consultation and program development with tribal governments regarding the delivery of services to American Indians living both on and off reservations. This office promotes government-to-government relations, and works to enhance tribal infrastructure, reduce disparities, and design effective programs.

Our *Communications Office* leads agency communications efforts. We respond to inquiries from the news media and prepare information that helps the general public understand the agency's services and human services policies.

Our *Office for Equity, Performance, and Development* is responsible for ensuring equal opportunity and nondiscrimination in employment and in delivering services to Minnesotans. We develop an engaged and culturally sensitive workforce that can provide services to DHS' diverse clientele.

Our *Community Relations* area supports, develops, and facilitates relationships between DHS and the community.

Our *County Relations* area takes a lead role in the agency's relationships with Minnesota's 87 counties. These counties administer most of the human services system that the agency oversees.

Our *Office of the Chief Financial Officer* provides fiscal services and controls the financial transactions of the agency. Core functions include preparing financial portions of business area budgets, paying agency obligations, federal fiscal reporting, administering the Parental Fee program, processing agency receipts and preparing employees' payroll.

- The Reports and Forecasts Division is responsible for meeting federal reporting requirements for economic assistance programs, Minnesota Health Care Programs, and the Supplemental Nutrition Assistance Program. Our staff provides forecasts of program caseloads and expenditures, provides fiscal analyses of proposed legislation affecting these programs, and responds to requests for statistical information on the programs.

Our *Compliance Office* is responsible for legal and compliance activities throughout the agency:

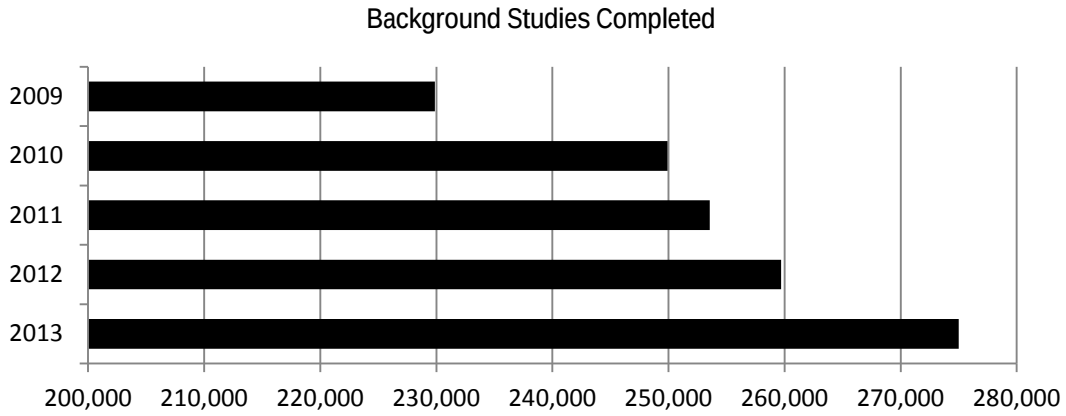
- The *Appeals and Regulations* area conducts hearings when applicants or recipients appeal a delay in their application or a denial, reduction, suspension or termination of economic assistance or social services. Our staff handles appeals from long-term care providers regarding the payment rates established.
- The *Contracts* office provides legal analysis and advice regarding contract development and management.
- The *Internal Audits Office* provides an independent examination and evaluation of the agency's fiscal and program management. Our staff conducts audits of the agency's grantees, contractors, vendors, and counties. We also conduct investigations of suspected or alleged misuse of state resources.
- The *Rulemaking* area develops the administrative rules that govern agency programs and define client benefits. Our staff also publishes bulletins concerning program changes and other issues affecting agency clients and programs.
- The *Legal Management Office* provides legal advice, counsel, and direction for all of DHS, including data practices.

Operations' work supports the following strategies in the DHS Framework for the Future 2014:

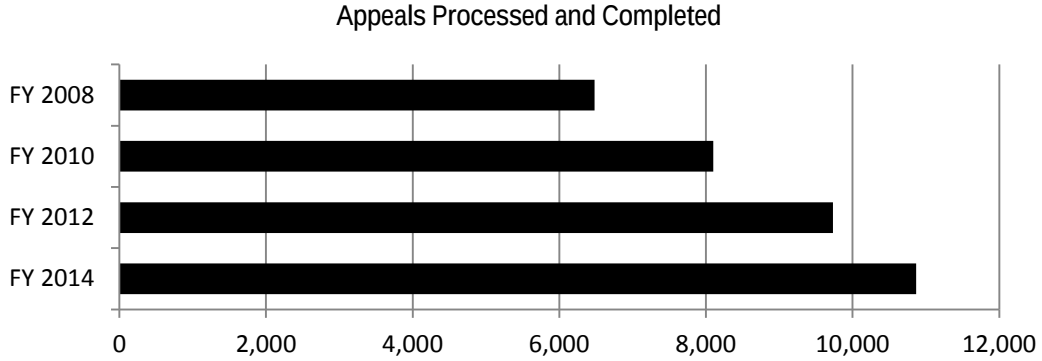
- Better protect children and vulnerable adults in families and facilities, especially those directly in our care
- Expand employee engagement efforts across the agency
- Build new working partnerships and governance arrangements with counties and tribes to improve client services
- Develop a more accurate and efficient background study process
- Increase fraud investigations of Child Care Assistance providers
- Implement new regulatory oversight to support people living safely in homes and communities
- Implement onsite enrollment screening requirements for medium- and high-risk providers
- Expand provider investigations through Recovery Act contracts

RESULTS

Number of background studies completed annually: Individuals who have direct contact with clients



Number of Appeals processed and completed by fiscal year



Operations' legal authority is in several places in state law: M.S. chapter 245A (Human Services Licensing); chapter 245C (Human Services Background Studies) and sections 144.057, 144A.476, and 524.5-118; and chapter 245D (Home and Community-Based Services Standards).

Additional statutes give the agency authority to investigate fraud: M.S. sections 119B.125, 152.126, 256.987, 256D.024, 256J.26, 256J.38, 609.821, 626.5533, and chapter 245E (Child Care Assistance Program Fraud Investigations).

M.S. sections 626.556 and 626.557 authorize the agency's work conducting background studies and investigating reports related to maltreatment of minors and of vulnerable adults.

M.S. chapter 256 (Human Services) provides authority for many of the agency's general administrative activities. M.S. sections 256.045 to 256.046 give authority for the agency's appeals activities.

Program: Central Office Operations
Activity: Children & Families

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000252

AT A GLANCE

- Provides child support services to more than 398,000 custodial and non-custodial parents annually and 270,000 children
- Provides child care assistance to more than 31,000 children in an average month
- 1,076 children were either adopted or had a permanent transfer of legal custody to a relative in 2013
- More than 500,000 Minnesotans receive help through the Supplemental Nutrition Assistance Program (SNAP) every month
- More than 2,900 individuals in 1,300 households receive transitional housing services annually
- More than 3,300 individuals at risk of or experiencing long-term homelessness receive supportive services annually
- All funds administrative spending for the Children and Families activity for FY 2013 was $37.0 million. This represented 0.3% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Children and Families administers and provides administrative support to counties, tribes and social service agencies for programs that provide child safety and well-being services, and for economic assistance programs serving low-income families, children and low-income adults.

These services help ensure that low-income people receive the support they need to be safe and help build stable families and communities. Programs administered in this area seek to:

- Keep more people fed and healthy by increasing nutrition assistance participation;
- Keep more children out of foster care and safely with their families;
- Decrease the disproportionate number of children of color in out-of-home placements; and,
- Increase access to high quality child care.

Our statewide administration of these programs ensures that federal funds are used according to federal regulations, resources and services are distributed equitably across the state, and quality standards are maintained.

SERVICES PROVIDED

In the Children and Families Services Administration our staff provides administrative direction and supports to counties, tribes and community agencies. Our work includes:

- Researching, recommending and implementing statewide policy and programs
- Managing grants
- Training and giving technical assistance to counties, tribes and grantees
- Evaluating and auditing service delivery
- Conducting quality assurance reviews to make sure that effective services are delivered efficiently and consistently across the state

We are organized into five principal Divisions: Child Safety and Permanency, Child Support, Community Partnerships and Child Care Services, Economic Assistance and Employment Supports, and Management Operations.

Our areas of responsibility include administering several forecasted programs: the Minnesota Family Investment Program (MFIP) and Diversionary Work Program, General Assistance, Group Residential Housing, Minnesota Supplemental Aid and MFIP Child Care Assistance. Our staff also supports grant programs that provide funding for housing, food and child welfare services. We also administer the federal Supplemental Nutrition Assistance Program (SNAP) in this area. We provide oversight of statewide child welfare services that focus on ensuring children's safety while supporting families. We ensure that core safety services focus on preventing or remedying neglect, and providing basic food, housing and other supports to the most at-risk adults and children. We review approximately 1,920 SNAP cases annually to see if benefits and eligibility were determined correctly. In addition, we review overall

county and tribal administration and management of SNAP in 30-35 agencies each year. In 2013, we provided almost 850 classroom and over 3,700 on-line trainings for county staff on SNAP, family cash assistance and child care assistance.

Funding for our programs comes from a combination of state and federal dollars. Major federal block grants that support programs in our Administration include Temporary Assistance for Needy Families, the Child Care and Development Fund, the Social Services Block Grant and the Community Services Block Grant. Funding from these four federal sources totaled $382 million in fiscal year 2014.

We support the following strategies in the DHS Framework for the Future 2014:

- Better protect children and vulnerable adults in families and facilities, especially those directly in our care
- Keep more people fed and healthy by increasing nutrition assistance participation, especially for seniors
- Increase access to prevention, outreach, shelter, and housing for at-risk and homeless youth
- Expand employee engagement efforts across the agency
- Build new working partnerships and governance arrangements with counties and tribes to improve client services
- Lower the disproportionate number of children of color in out-of-home placements
- Decrease the number of children in foster care waiting for adoption
- Increase the number of children in underserved communities enrolled in quality child care settings
- Reduce Supplemental Nutrition Assistance Program error rate

RESULTS

We provide administrative support to a broad array of programs and services for low-income families and adults and children. We report some key measures related to child protection and to the SNAP program.

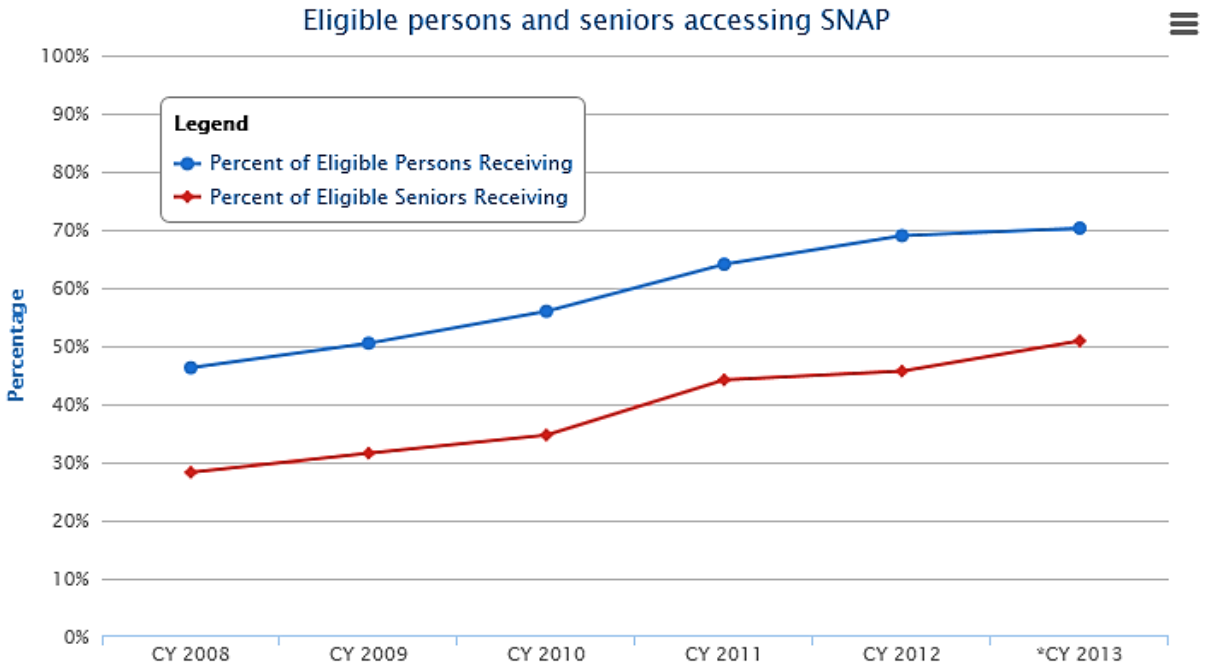
Type of Measure	*Description of Measure*	*2010*	*2011*	*2012*	*2013*
Quality	Percent of children not experiencing repeated abuse or neglect within 6 months of a prior report	95.1%	95.6%	97.5%	97.2%
Quality	Percent of children reunified with parents or living with relatives in fewer than 12 months from latest removal from home	84.5%	85.7%	85.9%	85.1%
Quality	Percent of children adopted in fewer than 24 months from latest removal from home	48.2%	48.1%	49.4%	54.7%

Performance Measures notes:

All measures in the above table are from Minnesota's Child Welfare Reports, 2010-2013. Child Protection statistical reports are posted on the DHS Child Protection Publications page. Also see the DHS Child Welfare Data Dashboard.

SNAP Participation Rate

We report an additional quality measure, graphed below, that shows increased participation in the SNAP program to help keep people fed and healthy.



SNAP data is from the DHS Dashboard.

M.S. chapter 256 (Human Services) provides authority for many of the agency's general administrative activities. For specific programs administered under Children and Families, we list legal citations that apply to the program at the end of each budget narrative.

Program: Central Office Operations
Activity: Health Care

AT A GLANCE

- Medical Assistance provided coverage for an average of 739,158 people each month during FY 2013.
- MinnesotaCare provided coverage for an average of 124,685 people each month during FY 2013.
- In FY2013 our member services call center fielded 119,932 calls.
- In FY2013 our provider help desk fielded 370,384 calls.
- All funds administrative spending for the Health Care activity for FY 2013 was $56.8 million. This represents 0.5% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The Minnesota Department of Human Services (DHS) Health Care Administration administers the Minnesota Health Care Programs (MHCP), including:

Medical Assistance (MA; Minnesota's Medicaid program) which provides health coverage for low-income people including children and families, people 65 or older, people who have disabilities and adults without children; and

MinnesotaCare which provides coverage for those who do not have access to affordable health care coverage.

These programs provide a health care insurance safety net for low-income families, elderly, disabled and very low-income adults without children.

Our goals are to:

- Increase the number of insured Minnesotans by helping eligible people get MA or MinnesotaCare coverage
- Improve and streamline Medicaid processes through the way we administer and deliver programs
- Improve the health outcomes, beneficiary experience and value of care delivered through MHCP
- Reform payment and delivery models by designing rates and models to reward quality and emphasize transparency
- Use research, data and analysis to develop policy recommendations, support DHS health care programs and evaluate results
- Encourage stakeholder communication to support our clients, partners and programs

SERVICES PROVIDED

The Health Care Administration's (HCA) Divisions and operational units include the following:

Office of the Assistant Commissioner

This office performs central functions including:

- Managing the partnership between DHS and the federal Centers for Medicare and Medicaid Services for all Medicaid state plan and waiver services
- Care delivery and payment reform projects including the Integrated Health Partnerships and the CMS State Innovation Models
- Office of the Medical Director
- Coordinating the development of recommendations on health care policy and legislation

Health Care Eligibility Operations

- Processes applications and makes eligibility determinations for MinnesotaCare and the Minnesota Family Planning Program
- This unit includes the State Medical Review Team that conducts 10,000-12,000 disability determinations for the purposes of Medical Assistance eligibility
- Provides ongoing case maintenance and processes changes in circumstance

Health Care Eligibility and Access

- Administers all eligibility policy for the Medical Assistance and MinnesotaCare programs including long term care services.
- Provides training, education, and support for county social service agencies, tribal governments, and other entities processing applications for MHCP
- Develops business requirements for eligibility systems including MAXIS, MMIS, and MNsure (ITS)

Purchasing and Service Delivery (PSD)

- PSD coordinates the purchasing and delivery of services in state health care programs and administers coverage and benefit policy
- Establishes payment policies and calculations for fee-for-service and managed care rates
- Negotiates and manages annual contracts between DHS and managed care organizations

Member and Provider Services (MPS)

- MPS supports MHCP members and providers, conducts benefits recovery and claims processing, runs the member and provider call centers, enrolls health care providers, and manages all provider training and communication regarding the health care programs
- Benefits Recovery Unit assures that Medical Assistance program remains the payer of last resort by billing any insurers or other parties with primary responsibility for paying medical claims
- Responds to enrollee phone calls regarding eligibility, covered services, and provider availability

Healthcare Research and Quality

- Conducts data analysis, research, and data reporting responsibilities for the MHCP and oversees quality assurance activities for the managed care organizations contracting with DHS
- Uses heath care claims data to inform policy and program development and monitors the quality of health care services purchased by DHS

Our staff shares some health care coverage policy and rates development functions with the Continuing Care and Chemical and Mental Health Services administrations for the services under the purview of those other administrations.

Our work supports the following strategies in the DHS Framework for the Future: 2014 (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6464C-ENG):

- Improve access to affordable health care
- Integrate primary care, behavioral health and long-term care
- Expand employee engagement efforts across the agency
- Expand the number of providers and enrollees participating in Integrated Health Partnerships
- Modernize eligibility and enrollment systems
- Reduce the gap in access and outcomes for health care in cultural and ethnic communities
- Hold managed care plans accountable for health equity outcomes related to depression, diabetes and well child visits

RESULTS

Minnesota is consistently a national leader in promoting and implementing policy and payment initiatives that improve access, quality and cost-effectiveness of services provided through publicly funded health care programs. We monitor performance measures that help us get at key actions and strategies. If DHS can quickly reimburse providers who serve our recipients, those providers may be more apt to serve recipients of Minnesota's public health care programs. Treating people in emergency rooms is more expensive than keeping them healthy to begin with, so increasing people's access to health insurance can increase their access to preventive care, which keeps costs down and helps people live better lives.

While these improvements in health care access and improving the quality of care are important first steps, there is more work to do. In 2014 the agency signed agreements with three additional providers to participate in the IHP demonstration project, and more will be added in 2015. Our staff continues working on further simplifications of the enrollment and renewal processes. More work is needed to continue reducing the gaps in access and outcomes between people covered by public health care programs and people with private insurance. As access expands, we see increased demand for customer service for both enrollees and health care providers.

Performance Measure	*Previous*	*Current*	*Dates*
Percent of electronically submitted claims paid within two days[1]	98.5%	98.27%	FY2012 to FY2013
Number of Health Systems Enrolled in an Integrated Health Partnership[2]	6	9	2013 to 2014
Percent of total MA and MinnesotaCare program enrollees served by an IHP[5]	12%	16%	2013 to 2014
Total MA Benefit Recoveries (excluding fraud and cost avoidance)[4]	$44.4 million	$75.3 million	FY2011 to FY2013

Performance Measure Notes:

1. Source: FY 2013 Member and Provider Services Operational Statistics. Compares Fiscal year 2012 (Previous) to Fiscal year 2013 (Current). Our goal is to pay 98 percent of electronically submitted claims within two days. The trend is stable.
2. Measure is the number of providers enrolled in an Integrated Health Partnership to serve MA and MinnesotaCare recipients. Compares 2013 (Previous) to 2014 (Current)
3. Measure is the percentage of Minnesota Health Care Program Enrollees served by an IHP provider. Compares 2013 (Previous) and 2014 (Current).
4. Source: Member and Provider Services Operational Statistics. Measure is the total amount of recoveries conducted by the benefit recovery unit at DHS and contractors performing recovery activities on its behalf. Compares FY 2011 (Previous) and FY 2013 (Current).

M.S. chapter 256 (Human Services - https://www.revisor.mn.gov/statutes/?id=256) provides authority for many of the agency's general administrative activities. Some of the authority to administer MA is also in that chapter. Additional legal authority to administer MA is in M.S. chapter 256B (Medical Assistance for Needy Persons - https://www.revisor.mn.gov/statutes/?id=256B). Our authority to administer MinnesotaCare is in M.S. chapter 256L (https://www.revisor.mn.gov/statutes/?id=256L).

Program: Central Office Operations
Activity: Continuing Care

AT A GLANCE

- Oversees services to over 400,000 people each year with a value of more than $3.6 billion each year in state and federal funds
- Performs statewide human services planning and develops and implements policy
- Obtains, allocates, and manages resources, contracts, and grants
- Sets standards for service development and delivery and monitors for compliance and evaluation
- Provides technical assistance and training to county and tribal agencies and supports local innovation and quality improvement efforts
- All funds administrative spending for the Continuing Care activity for FY 2013 was $25.9 million. This represented 0.2% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The Continuing Care Administration administers Minnesota's publicly funded long-term care programs and services for people with disabilities, older Minnesotans, and their families. Our Administration's mission is to improve the dignity, health and independence of the people we serve.

We have four goals:

- Support and enhance the quality of life for older people and people with disabilities
- Manage an equitable and sustainable long-term care system that maximizes value
- Continuously improve how we administer services
- Promote professional excellence and engagement in our work

SERVICES PROVIDED

The Continuing Care Administration is composed of the following Divisions and units, each charged with particular areas of responsibility:

- Aging and Adult Services Division
- Planning and Aging 2030
- Nursing Facility Rates and Policy Division
- Deaf and Hard of Hearing Services Division
- Disability Services Division
- Fiscal Analysis and Performance Measurement
- Operations and Central Functions

Our work includes:

- Administering Medical Assistance long-term care waiver programs and state plan services. This includes developing, seeking authority for and implementing policies, projects, and research. We also oversee state and federal grants and contracts, including Senior Nutrition Grants and Moving Home Minnesota, a federal Money Follows the Person Rebalancing Demonstration Program. These programs serve both seniors and people with disabilities;
- Providing training, education, assistance, advocacy and direct service, including overseeing the state's adult protective services system;
- Managing of nursing home, disability waivers, Intermediate Care Facilities for persons with Developmental Disabilities, and Day Training and Habilitation provider rates;
- Monitoring service quality by doing evaluations and measuring results using county waiver reviews;
- Staffing of the Governor-appointed Minnesota Board on Aging, the Ombudsman for Long-Term Care, and the Commission of Deaf, DeafBlind, and Hard of Hearing Minnesotans, a state agency administratively placed within DHS;
- Working to improve the quality of services and share best practices across providers;
- Providing administrative, financial, and operational management and support; and
- Providing outreach, staff support and technical assistance to stakeholders and stakeholder workgroups.

Direct services we provide include:

- Staffing statewide regional service centers that help people who are deaf, deafblind, hard-of-hearing and late deafened get access to community resources and other services;
- Delivering mental health services in American Sign Language for people who are deaf, deafblind and hard-of-hearing;
- Running the Telephone Equipment Distribution Program, which offers telecommunications equipment to people with hearing loss or other disabilities and who have difficulty using a regular telephone;
- Offering online education presented in American Sign Language on advocacy in education, employment, health care, technology, public access, voter engagement, and heritage;
- Running HIV/AIDS programs that help people get and keep needed health care coverage;
- Providing long-term care ombudsman services, which help people resolve complaints and keep their services; and
- Developing, maintaining, and publishing provider quality rankings for consumers using the nursing home and HCBS report cards.

We support the following strategies in the DHS Framework for the Future: 2014:

- Serve more people in their own homes, communities and integrated workplaces
- Keep more people fed and healthy by increasing nutrition assistance participation, especially for seniors
- Enhance long-term care planning
- Implement a new autism benefit for children
- Expand employee engagement efforts across the agency
- Evaluate quality of life and care for people receiving services by using online report cards for home and community-based services and nursing facilities
- Launch the new Community First Services and Supports to support people in their communities
- Streamline the adult protection system

RESULTS

We use several information sources and data to monitor and evaluate quality outcomes and provider performance. Much of the information we analyze is from the DHS Data Warehouse or from surveys of consumers, providers, and lead agencies. More explanation of these measures is in the performance notes below the table.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	1. Percent of waiver review follow-up cases corrected after issuance of corrective actions	84%	93%	2010 to 2013
Quality	2. Average statewide risk-adjusted nursing facility quality of care score out of a possible 100 points	61.4	67.7	Mar. 2012 to Mar. 2014
Result	3. Percent of working age consumers on disability waiver programs with earnings	43.8%	44.6%	Dec. 2009 to Dec. 2013
Result	4. Percent of seniors served by home and community-based services	59.3%	68.4%	2008 to 2013

More information is available on the DHS Dashboard and the Continuing Care Performance Report.

Performance Notes:

1. Measure one compares 2010 data to 2013 data. 2010 data is earliest available. Source: Waiver review database
2. Measure two compares March 2012 data to March 2014 data. Source: Minimum Data Set resident assessments.
3. Measure three compares monthly earnings from Dec. 2009 to Dec. 2013 data for all disability waiver programs. "Working age" is age 22-64. Source: DHS Data Warehouse.
4. Measure four compares FY2008 to FY2013. This measure shows the percentage of seniors receiving publicly-funded long-term care services who receive HCBS services through the Elderly Waiver, Alternative Care, or home care programs instead of nursing home services. Source: February 2014 Forecast

M.S. chapter 256 (Human Services) provides authority for many of the agency's general administrative activities. Some of the authority to administer MA is also in that chapter. Additional legal authority to administer MA is in M.S. chapter 256B (Medical Assistance for Needy Persons). For other activities administered under Continuing Care, we list legal citations that apply to the program at the end of each budget narrative.

Program: Central Office Operations
Activity: Chemical & Mental Health

AT A GLANCE

- Provides policy oversight and administers funding for public chemical and mental health services to thousands of Minnesotans.
- 36,991 people received substance abuse treatment services in CY2013.
- 124,587adults received mental health services through the Minnesota Health Care Programs (MHCP) in CY 2013.
- 17,589 adults received mental health case management services through the MHCP in CY 2013
- 70,100 children and youth receive publically funded mental health services each year.
- All funds administrative spending for the Chemical and Mental Health activity for FY 2013 was $9.9 million. This represented 0.1% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The Chemical and Mental Health Services Administration within the Department of Human Services leads efforts to research, recommend, implement and evaluate policy for chemical and mental health services in Minnesota, including those provided through the Minnesota Health Care Programs (MHCP) — Medical Assistance and MinnesotaCare. Our goal is to support the development and ongoing viability of an accessible and comprehensive service delivery system for persons with mental illness and/or substance addiction. Our current work focuses on integrating behavioral health care with physical health care, implementing evidence-based practices, prevention, and early intervention.

SERVICES PROVIDED

We have three divisions within the Chemical and Mental Health Services Administration (CMHS):

- Adult Mental Health Division
- Alcohol and Drug Abuse Division
- Children's Mental Health Division

Collaborating both with partners within state agencies and in local communities, our Administration shapes and implements public policy on mental health and chemical dependency treatment and prevention services. Specifically, our staff:

- Leads efforts to shape and implement public policy directed towards prevention, early intervention, and treatment of persons with a mental illness or chemical dependency.
- Administers payment policy and manages grant programs for mental health and chemical dependency services, such as the Consolidated Chemical Dependency Treatment Fund, Minnesota Health Care Programs, Adult Mental Health Grants, Child Mental Health Grants and Chemical Dependency Treatment Support Grants.
- Works to encourage the development of local service capacity, including related professional workforce development activities.
- Trains and guides service delivery partners on best practices.
- Provides supervision, guidance, and oversight to service delivery partners including counties, tribes and non-profit providers.
- Partners with stakeholders to improve prevention and early intervention efforts and the service delivery system.
- Finds funding outside of state appropriations and seeks such opportunities to leverage goals.

Major grant programs we administer include the:

- Consolidated Chemical Dependency Treatment Fund (CD Treatment Fund)
- Adult Mental Health Integrated Fund
- Compulsive Gambling Program
- School-based Children's Mental Health Grants
- Federal Substance Abuse Prevention and Treatment Block Grant
- Federal Community Mental Health Services Block Grant

We support the following strategies in the DHS Framework for the Future: 2014 (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6464C-ENG).

- Reduce the rate of prenatal exposure to alcohol or drugs
- Integrate primary care, behavioral health and long-term care
- Expand employee engagement efforts across the agency
- Build new working partnerships and governance arrangements with counties and tribes to improve client services
- Reduce the gap in access and outcomes for health care in cultural and ethnic communities

RESULTS

While we do not provide direct services to persons working to recover from mental health and substance abuse problems, or work provides the guidance and resources that facilitate positive change. Some outcomes associated with current CMHS initiatives include:

Type of Measure	Name of Measure	Previous	Current	Dates
Quantity	Percent of children in the child welfare system who received a mental health screening.[1]	56.6%	58.9%	2010 vs. 2011
Quantity	The percent of adults in *Assertive Community Treatment (ACT)* who receive an annual comprehensive preventative physical exam.[2]	26.5%	27.8%	2012 vs. 2013
Result	Past 30 day use of alcohol by youth in funded communities.[3]	24.5%	17.9%	2010 vs. 2013
Result	Percentage of babies born with negative toxicology reports.[4]	88%	81%	2011 vs. 2012

Performance Measure Notes:

1. With parental consent, counties conduct mental health screenings for children in the child welfare and juvenile justice systems who have not had a recent assessment. The Previous measure is Calendar Year 2010; the Current measure is CY 2011. (Source: Minnesota Department of Human Services Dashboard, http://dashboard.dhs.state.mn.us/)
2. Compares CY 2012 (Previous) and CY 2013 (Current). The measure is based on ACT recipients who are not Medicare eligible and who are enrolled 12 months in MA or Minnesota Care. (Source: Minnesota Department of Human Services Dashboard, http://dashboard.dhs.state.mn.us/)
3. This measure consists of data as reported in the *Minnesota Student Survey* for 9th grade users. Previous represents calendar year CY 2010 and Current represents CY 2013.
4. The percentage of babies with negative toxicology results during a 12-month period, born to women served by the state Women's Recovery grants. Previous represents FY 2011 and Current represents FY 2012.

M.S. chapter 256 (Human Services, https://www.revisor.mn.gov/statutes/?id=256) provides the legal authority for many of the agency's general administrative activities.
M.S. sections 245.461 – 245.4889 (https://www.revisor.mn.gov/statutes/?id=245), and chapters 254A (https://www.revisor.mn.gov/statutes/?id=254A), and 254B (https://www.revisor.mn.gov/statutes/?id=254B), provide authority for Chemical and Mental Health services.
M.S. section 256B.0625 (https://www.revisor.mn.gov/statutes/?id=256B.0625), provides authority to include chemical and mental health treatment benefits in Minnesota Health Care Programs.

Program: Forecasted Programs
Activity: MFIP / DWP

MFIP (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_004112)
DWP (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_028634)

AT A GLANCE

- In 2013, MFIP and DWP provided assistance for approximately 40,000 low-income families a month, 71 percent of those served are children.
- The average monthly payment for an MFIP family was $735, including the food portion of MFIP. The average monthly cash payment for a DWP family was $403.
- All funds spending for the MFIP/DWP activity for FY 2013 was $315.9 million. This represented 2.6% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Minnesota Family Investment Program (MFIP) and Diversionary Work Program (DWP) provide temporary financial support to help meet the basic needs of low-income families with children and low-income pregnant women.

Half the parents receiving MFIP or DWP were employed in the three months before they turned to the program for assistance. Common causes for job losses are layoff, reduced hours, birth of a baby by a parent with no leave time, need to care for an ill child or spouse with a disability, or transportation and child care costs that wages do not cover.

The goal of these related programs is to stabilize families and improve economic outcomes through employment. Without these benefits, families have little or no other resources available to help meet their basic needs.

These programs are funded with a combination of state, federal Supplemental Nutrition Assistance Program (SNAP), and federal Temporary Assistance for Needy Families (TANF) funds. Counties and tribes administer the MFIP and DWP programs.

SERVICES PROVIDED

MFIP provides job counseling, cash assistance and food assistance to low-income families with children and to low-income pregnant women. Families receive time limited benefits (60 months or fewer). The amount of benefits is based on family size and other sources of income. Families may request an extension of their benefits if, for example, an eligible adult has a disability or needs to care for a family member with a disability. A family of three - a parent with two children - with no other income can receive $532 in financial assistance and $446 in SNAP benefits per month. The benefits are structured to reward families who work and are gradually reduced as income rises. Parents are required to participate in employment services to develop the skills needed to move into the labor market as soon as possible. Families may also be eligible for child care assistance and for health care coverage under Medical Assistance.

DWP is designed to meet specific crisis situations and help families move to employment rather than go on MFIP. The program includes intensive, up-front services to focus on families' strengths and break down barriers to work. Families can participate in the program for four months within a 12-month period. A family receives cash benefits based on its housing, utility costs and personal needs up to a maximum based on the number of people in the family. Housing and utility costs are paid directly to the landlord or utility company. The maximum that a family of three – a parent with two children –can receive is $532 in financial assistance. Most families are also eligible for SNAP benefits, child care assistance and for health care coverage under Medical Assistance.

Beginning July 1, 2015, families who receive MFIP (with some exemptions) may also be eligible for a housing assistance grant of $110 per month if they do not receive a rental subsidy through the federal Department of Housing and Urban Development.

RESULTS

The two key measures in MFIP are:

- The Self-Support Index (S-SI) is a results measure. The S-SI gives the percentage of adults eligible for MFIP or DWP in a quarter who have left assistance or are working at least 30 hours per week three years later. Customized targets are set for each county or tribe using characteristics of the people served and local economic conditions. State law requires the

Department of Human Services to use the Self-Support Index to allocate performance bonus funds. The following chart shows that about two-thirds of participants have left MFIP and/or are working at least 30 hours per week three years after a baseline period.

Year ending in March of:	S-SI
2008	71.8%
2009	68.9%
2010	67.0%
2011	65.2%
2012	65.3%
2013	66.9%
2014	68.5%

- The federal Work Participation Rate (WPR) is a measure of quantity. The WPR reflects parents engaging in work and specific work-related activities. We calculate an estimated WPR for counties, county consortiums, and tribes monthly and it is annualized to allocate performance bonus funds. (Beginning in calendar year 2016, the bonus will be based solely on the S-SI.) The following chart shows the WPR for 2008 to 2013.

Calendar Year	WPR
2008	29.9%
2009	29.8%
2010	40.2%
2011	43.9%
2012*	45.3%
2013*	45.1%

*State estimate (Federal figures not yet released)

We also track another measure developed for statewide and county performance:

- SNAP and Cash Assistance Timeliness is the percentage of approved public assistance applications with benefits issued within mandated timelines. This is a measure of quality that helps determine how well counties are able to help people meet their basic needs.

Calendar Year	Timeliness
2008	78.7%
2009	78.3%
2010	78.9%
2011	80.1%
2012	75.9%
2013	75.7%

The state legal authority for the Minnesota Family Investment Program (MFIP) and Diversionary Work Program (DWP) is under M.S. chapter 256J (https://www.revisor.mn.gov/statutes/?id=256J).

Program: Forecasted Programs
Activity: MFIP Child Care Assistance

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008688

AT A GLANCE

- In 2013 MFIP Child Care Assistance paid for child care for 15,681 children in 8,389 families in an average month.
- The average monthly assistance per family was $1,117.
- All funds spending for the MFIP Child Care Assistance activity for FY 2013 was $118.0 million. This represented 1% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

A 2009 study commissioned by the Department of Human Services and conducted by Wilder Research found that about three quarters of Minnesota households with children ages 12 and younger use child care. These families are challenged to find affordable child care that fits their preferences and needs. In households with low incomes, 20 percent of parents reported that child care problems interfered with their getting or keeping a job in the past year. Without this program, many low-income families would not be able to pay for child care and would be unable to work or pursue education leading to work.

Minnesota Family Investment Program (MFIP) Child Care Assistance provides financial subsidies to help low-income families pay for child care so children are well cared for and prepared to enter school ready to learn. The program serves families who currently or recently participated in MFIP or in the related Diversionary Work Program (DWP).

SERVICES PROVIDED

The program provides supports to help improve outcomes for the most at risk children and their families by increasing access to high quality child care.

The following families are eligible to receive MFIP child care assistance or Transition Year child care assistance once they leave MFIP:

- MFIP and DWP families who are employed, pursuing employment, or participating in employment, training or social services activities authorized in approved employment plans
- Employed families who are in their first year off MFIP or DWP (this is known as the “transition year”)
- Families in counties with a Basic Sliding Fee (BSF) child care waiting list who have had their transition year extended
- Parents under age 21 who are pursuing a high school or general equivalency diploma (GED), do not receive MFIP benefits, and reside in a county that has a BSF waiting list that includes parents under age 21.

As family income increases, so does the amount of child care expenses paid by the family in the form of copayments. All families receiving child care assistance and earning 75 percent or more of the federal poverty guideline make copayments based on family income. A family of three leaving MFIP and earning 115 percent of the federal poverty level ($22,460) would have a total biweekly child care provider payment of $24 for all children in child care.

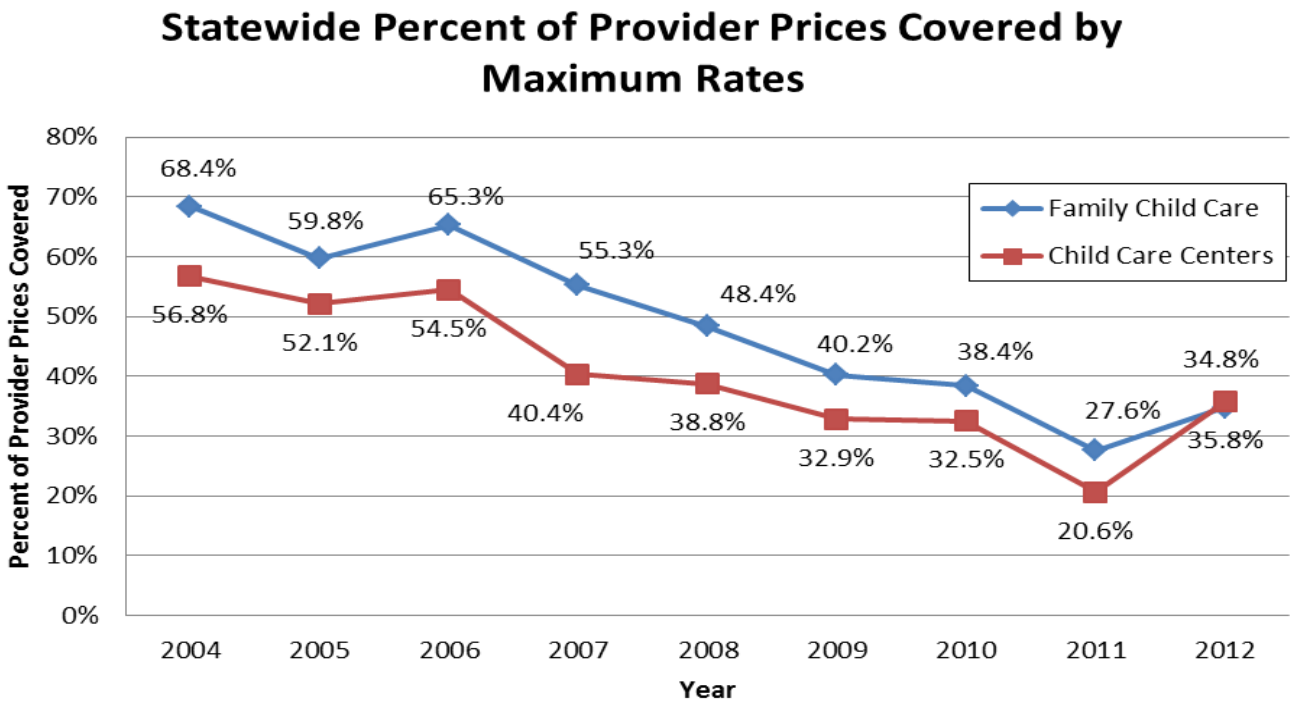
The MFIP child care assistance activity is part of the state’s Child Care Assistance Program. Maximum rates in the Child Care Assistance Program are set in state law. Maximum rates are set for each type of care: child care centers, family child care and legal non-licensed child care. Providers are paid at the rate they charge private pay families, up to this limit. The program pays a higher rate to child care providers who provide high quality child care. Participation in high quality care increases the likelihood of children’s improved school readiness.

Child care must be provided by a legal child care provider over the age of 18 years. Allowable providers include legal nonlicensed family child care, license-exempt centers, licensed family child care and licensed child care centers. Families choose their providers in the private child care market. Counties administer the Child Care Assistance Program.

All families who meet eligibility requirements may receive this help. MFIP child care assistance is funded with state and federal funds that include the federal Child Care and Development Fund and the Temporary Assistance for Needy Families (TANF) fund.

Maximum rates paid to providers under the Child Care Assistance Program may not cover the full cost of child care. This may be a barrier for some families, if the family cannot find a provider in their community whose rates are covered by the maximum allowed under the program. The percent of child care provider rates that are fully covered by the Child Care Assistance Program increased when the maximum rates were raised in 2014, but the maximum rate paid remains low compared to rates in the market.

This quality measure shows approximately 35 percent of child care providers charge rates that are fully covered by the Child Care Assistance Program maximum rates.

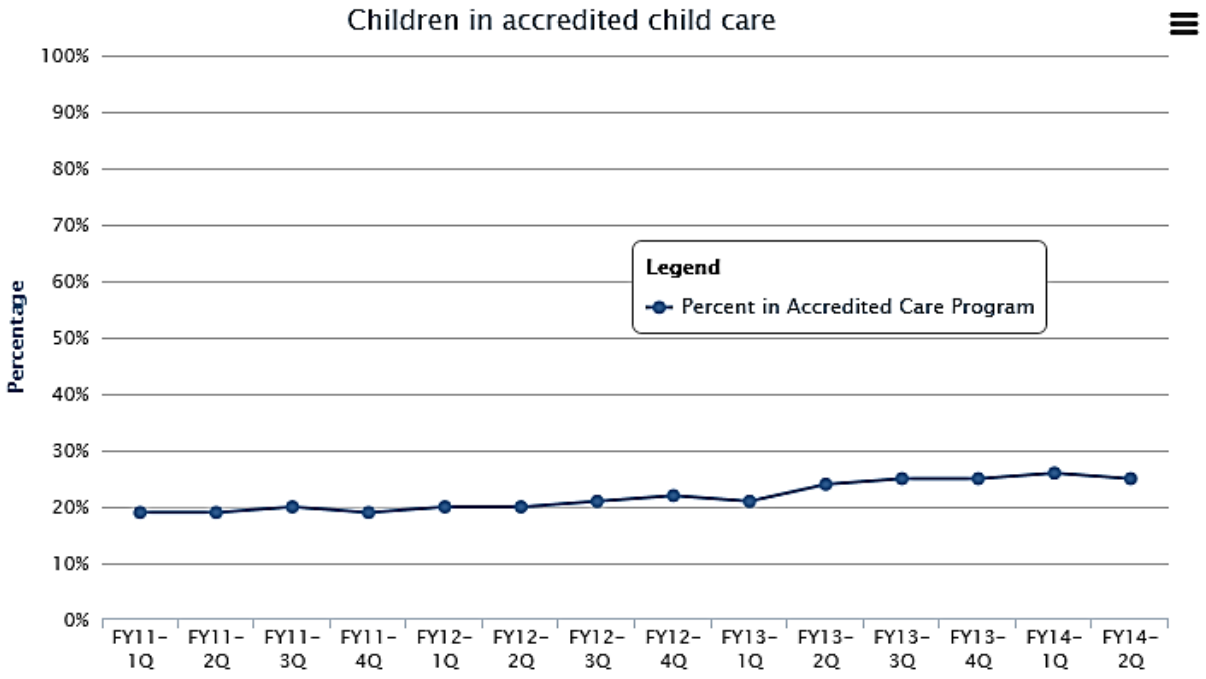


High quality early child care and education experiences are associated with better outcomes, particularly for children from low-income families. Parent Aware is Minnesota's rating tool for helping parents select high quality child care and early education programs.

Beginning in March 2014, the Child Care Assistance Program pays a rate increase to providers with higher ratings:

- Up to a 15 percent higher maximum rate is paid to providers with a Parent Aware three-star rating, or who meet certain accreditation or education standards established in statute.
- Up to a 20 percent higher maximum rate is paid to providers with a four-star Parent Aware rating.

Another quality measure, Children in Accredited Child Care, shows an increase over time in the percent of children served by the Child Care Assistance Program receiving care from a provider who met quality standards through an accredited child care program.



The data source for the percent of providers covered by maximum rates is a survey of provider prices conducted by the Department and used to determine the percent of providers who are covered by maximum rates.

The data source for children in accredited care is from MEC^2, Minnesota's child care electronic eligibility and payment system.

The legal authority for the MFIP/TY Child Care Assistance program is in M.S. chapter 119B (https://www.revisor.mn.gov/statutes/?id=119B)

Program: Forecasted Programs
Activity: General Assistance

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_002558

AT A GLANCE

- In December 2013, 22,635 Minnesotans were eligible for General Assistance.
- The typical monthly benefit is $203 for an individual and $260 for a couple.
- All funds spending for the General Assistance activity for FY 2013 was $51.6 million. This represents 0.4% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

General Assistance (GA) is the primary safety net for very low-income people without children who are unable to work and do not have enough money to meet their basic needs. The most common eligibility reason for people at enrollment is illness or incapacity (51 percent). GA helps meet some of their basic and emergency needs. Without additional income supports, these individuals would likely fall further into poverty and become homeless.

Many people receive these monthly cash benefits while they wait for more stable assistance such as SSI, a federal income supplement program that helps people who are aged, blind or have a disability and have little or no income. Thirty two percent of people eligible for GA have signed an Interim Assistance Agreement. That indicates they plan to apply for other income benefits such as federal Supplemental Security Income (SSI) or Retirement, Survivors and Disability Income (RSDI).

SERVICES PROVIDED

The General Assistance (GA) program provides state-funded, monthly cash grants to people without children who have a serious illness, disabilities or other issues that limit their ability to work and are unable to fully support themselves. GA's maximum monthly benefit is $203 for a single adult, or about 21percent of the Federal Poverty Guideline of $972 per month for one person, and $260 for a couple. Additional emergency funds may be available if a recipient cannot pay for basic needs and the person's health or safety is at risk because of this. People eligible for GA may also be eligible for health care coverage under Medical Assistance.

The Department of Human Services (DHS) works with the federal Social Security Administration and the state's Disability Linkage Line® to identify ways to streamline the disability determination process. DHS also connects recipients with resources to help them with the SSI application process. People who become eligible for SSI are no longer eligible for GA. They become eligible for Minnesota Supplemental Aid to supplement their SSI income.

DHS works with counties, tribes, homeless service providers and other non-profit agencies to advise on and administer the GA program.

RESULTS

GA is a safety net program that contributes to stabilizing crisis situations, avoiding homelessness and making connections to other resources, resulting in better outcomes.

GA recipients who may be eligible for SSI must apply and sign an Interim Assistance Agreement (IAA). If a person on GA is eligible for SSI, having an IAA in place allows the state to collect federal reimbursement for GA benefits paid while the person's application for SSI was pending. An increase in the percent of GA recipients with a signed IAA shows a better opportunity for stable income for recipients and state savings.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Percent of GA recipients with a signed Interim Assistance Agreement (IAA)	44.5%	45.5%	May 2013 May 2014

GA is a safety net for people who do not have adequate income or resources to meet their basic needs. It is intended to be short-term while they apply for other benefits, look for employment, or secure other income. It is not intended as a long-term solution to meet a person's basic needs. Data below shows that while 43-45 percent of cases are on the program for more than 12 months, only 23-26 percent of cases remain on the program after two years.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Percent of GA cases with more than 12 months of continuous GA usage	43.5%	45.9%	Dec. 2012 Dec. 2013
Quantity	Percent of GA cases with more than 24 months of continuous GA usage	23.9%	26%	Dec. 2012 Dec. 2013

One of the goals of the GA program is to help people prepare to obtain permanent work and become self-sufficient. Some features of GA act as work incentives. A person can work and still remain on GA if his or her earned income is minimal. For example, the GA program allows some earned income to be disregarded, and some work expenses to be deducted, when a person's GA eligibility and benefits are calculated.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Percent of GA cases with earned income	2.1%	2.1%	Dec. 2012 Dec. 2013

The source for these outcomes is the DHS report, December 2012 General Assistance Caseload: Cases and Eligible People (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6128E-ENG)

The legal authority for the General Assistance program is M.S. chapter 256D (https://www.revisor.mn.gov/statutes/?id=256D)

Program: Forecasted Programs
Activity: MN Supplemental Assistance

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_004114

AT A GLANCE

- In December 2013, 31,012 Minnesotans received Minnesota Supplemental Aid.
- The typical benefit is $81 for an individual and $111 for a couple.
- This supplements a typical monthly federal Supplemental Security Income (SSI) benefit of $721 for an individual living alone.
- All funds spending for the Minnesota Supplemental Aid activity for FY 2013 was $36.0 million. This represented 0.3% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Minnesota Supplemental Aid (MSA) helps to address homelessness and poverty in Minnesota. MSA benefits are intended to cover basic daily or special needs. Nearly half of MSA recipients are age 60 or older and 79 percent have a disability.

Minnesota established the MSA program in 1974. Federal maintenance-of-effort regulations require that states maintain payment levels that were in effect in March 1983, or the state risks losing Medicaid federal financial participation. MSA is a supplement to Minnesota recipients on the federal Supplemental Security Income (SSI) program. People who become eligible for SSI are eligible for MSA to supplement their SSI income.

SERVICES PROVIDED

The Minnesota Supplemental Aid (MSA) program provides a state-funded monthly cash supplement to help people who are aged, blind or disabled, and who receive federal Supplemental Security Income (SSI) benefits to meet basic needs that are not met by SSI alone. Some recipients who do not receive SSI because their income is too high may still be eligible for MSA if they meet other eligibility criteria.

In addition to a monthly benefit, housing assistance is available to recipients who qualify, adding $189 more to the MSA benefit to help pay housing costs. To be eligible for this housing assistance, applicants must:

- Be under age 65 at the time of application
- Have total housing costs in excess of 40 percent of their total income
- Apply for rental assistance if eligible
- Be relocating from an institution, or eligible for Medical Assistance personal care attendant services, or receiving waivered services and living in their own place.

MSA may also provide additional payments for other special needs such as special diets and household repairs or furnishings.

The Department of Human Services works with counties, tribes, the Social Security Administration, service providers, and other nonprofit agencies to identify people eligible for the program, and to advise and administer MSA program policy.

RESULTS

People who receive federal Supplemental Security Income are categorically eligible for MSA, but must apply for MSA in order to receive the benefits. The MSA program has had stable enrollment of around 30,000 individuals over time, but the number of adults who receive SSI and yet do not receive MSA is increasing. This indicates some people are not accessing the benefits they are eligible for. The Department of Human Services is working with the Social Security Administration to inform people about this benefit.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Results	Percent of SSI beneficiaries over age 18 who receive MSA	39.0	38.8	Dec. 2012 Dec. 2013

MSA helps provides additional money to help people who qualify and have high housing costs move into affordable housing or be able to afford their current housing costs.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Percent of MSA recipients who receive MSA housing assistance	1.8	2	Dec. 2012 Dec. 2013

The MSA and SSI programs support efforts of people who want to work. MSA follows work incentives used by the Social Security Administration to encourage people with disabilities to work. More needs to be done to support them in reaching their employment goals.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Percent of MSA recipients with earned income	1.08	1.19	Dec. 2012 Dec. 2013

The source of the data for the MSA measures is the DHS report, December 2012 Minnesota Supplemental Aid: Cases and Eligible People (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6143B-ENG) and the Social Security Administration report on SSI Recipients by State and County 2013 (http://www.socialsecurity.gov/policy/docs/statcomps/ssi_sc/2013/mn.html).

The legal authority for the Minnesota Supplemental Aid program is in M.S. chapter 256D: sections 256D.33 (https://www.revisor.mn.gov/statutes/?id=256D.33) to 256D.54 (https://www.revisor.mn.gov/statutes/?id=256D.54).

Program: Forecasted Programs
Activity: Group Residential Housing

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_002549

AT A GLANCE

- In 2013, the Group Residential Housing (GRH) program served a monthly average of 19,000 participants.
- The current GRH housing rate limit is $876 per month.
- The average monthly payment per recipient is $548.
- All funds spending for the Group Residential Housing activity for FY 2013 was $130.2 million. This represented 1.1% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Group Residential Housing (GRH) is a state-funded income supplement program that pays for room and board in approved locations for adults with low incomes who have a disability or are 65 years or older. Participants must meet a combination of eligibility requirements set by the federal Supplemental Security Income (SSI) program or state General Assistance program to qualify for help. GRH also has income and asset limits.

Seventeen percent of GRH recipients are seniors. Those who are younger than 65 years of age all have a combination of factors that limit their self-sufficiency, including a physical or mental health disability, visual impairment or chemical dependency.

Without GRH, program recipients likely would be in institutional placements or homeless.

SERVICES PROVIDED

The GRH rate is currently $876 per month. This rate is paid for residents in more than 5,765 state-licensed or registered settings in Minnesota. About 4,263 of those are adult foster care homes. Other settings include board and lodging facilities, supervised living facilities, boarding care homes, supportive housing and other assisted living facilities.

Housing providers receive payments on behalf of eligible recipients. The GRH monthly payment is to pay for rent, utilities, food, household supplies and other items needed to provide room and board to a recipient. A recipient may be required to pay a portion of his or her income directly to housing providers. GRH can pay for additional supportive services in some settings if a recipient is not eligible for home-and community- based waiver services.

County human services agencies process eligibility and payments for people in the program. Counties also manage GRH contracts with housing and service providers.

RESULTS

An increase in the number of GRH recipients who are no longer homeless shows efforts are working to reduce homelessness.

GRH recipients who may be eligible for SSI must apply and sign an Interim Assistance Agreement (IAA). If a person receiving GRH is eligible for SSI, having an IAA in place allows the state to collect federal reimbursement for state payments made while the person's application for SSI was pending. An increase in the percent of GRH recipients with a signed IAA shows a better opportunity for stable income for recipients and state savings.

An increase in the percent of GRH applications processed within 30 days shows people get the help they need more quickly.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Results	Number of GRH recipients moving out of homelessness	1,224	1,688	Dec 2011, Dec 2013
Quantity	Percent of GRH recipients with signed Interim Assistance Agreement	14.5%	14.6%	May 2013 May 2014
Quality	Percent of GRH applications processed within 30 days	59%	65%	May 2013 May 2014

The information in these measures comes from MAXIS administrative data.

The legal authority for the Group Residential Housing program is M.S. chapter 256I (https://www.revisor.mn.gov/statutes/?id=256I).

Program: Forecasted Programs
Activity: MinnesotaCare

http://www.dhs.state.mn.us/main/id_006255

AT A GLANCE

- Beginning January 1, 2015, MinnesotaCare will operate as a Basic Health Plan under the Affordable Care Act
- In FY 2013, MinnesotaCare had an average monthly enrollment of 124,685
- All funds spending for the MinnesotaCare grants activity for FY 2013 was $571.2 million. This represented 4.7% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

MinnesotaCare provides comprehensive health care coverage for low-income working families and adults in Minnesota. MinnesotaCare serves clients who do not have access to affordable health insurance and have higher income levels than those served on the Medical Assistance program. Unlike Medical Assistance, MinnesotaCare requires enrollee premiums and does not include coverage for long term care services or supports.

Historically, MinnesotaCare draws on appropriations from the health care access fund, federal Medicaid funds, and from enrollee premiums. During the 2013 fiscal year, about 48% of the program costs were covered by state funds, 45% from federal funds, and 7% from enrollee premiums.

Changes to MinnesotaCare eligibility requirements and covered services signed into law in 2013 made the program eligible to receive Basic Health Plan (BHP) funding under the Affordable Care Act (ACA). In 2014, MinnesotaCare operates under a one-year extension of the state's current federal Medicaid waiver and receives a 50 percent federal match for health care coverage provided to enrollees. Beginning calendar year 2015 and after, Minnesota will receive BHP funding for MinnesotaCare equal to 95 percent of the federal subsidies that would otherwise be available to eligible people enrolled in private health care coverage through MNsure, the state's health insurance exchange.

SERVICES PROVIDED

MinnesotaCare covers a broad range of health care services including:

- Primary and preventive care,
- Inpatient and outpatient hospital care,
- Coverage for prescription drugs,
- Chemical dependency treatment,
- Mental health services, and
- Oral health services.

MinnesotaCare now has a more uniform benefit policy for all enrollees in the program. State law passed in 2013 removed a $10,000 cap on inpatient hospital benefits and other differences in the coverage for certain adults in the program. People eligible for Medical Assistance are no longer eligible for MinnesotaCare.

The Department of Human Services (DHS) contracts with non-profit health plans to provide services through their provider networks to MinnesotaCare enrollees.

MinnesotaCare is available to: non-pregnant adults and 19 and 20 year olds with a household income between 138 and 200 percent of federal poverty guidelines (FPG), children under age 19 with household income under 200 percent of FPG who are ineligible for Medical Assistance due to federal household composition rules, and lawfully present noncitizens with household income up to 200 percent of FPG.

People formerly eligible for MinnesotaCare, including pregnant women and most children with household income up to 275 percent of FPG, and adults below 138 percent of FPG, became eligible for the Medical Assistance program in January 2014. As a result of the state law changes to the income eligibility standards of the two programs, about 110,000 MinnesotaCare recipients transitioned to coverage in the Medical Assistance program in January 2014. The law change also ended MinnesotaCare coverage for adults with

income between 200 percent and 275 percent of FPG. Most of the adults in this income range are eligible for subsidies to purchase health insurance through MNsure.

People seeking coverage under MinnesotaCare can apply directly through the MNsure web site or by submitting a paper application to MNsure, to DHS, or to their county human services or tribal office. Applicants are not eligible if they have access to affordable health insurance coverage through an employer. There are no health condition barriers for eligibility, but applicants must meet income guidelines and pay a premium (if applicable) to receive coverage.1 Premiums are based on income and are charged for each enrollee, up to a maximum of $50 per month in 2014.

INNOVATIONS UNDERWAY

DHS works with many stakeholders to determine how we can improve our health care programs.

As part of Minnesota's commitment to deliver quality health care more efficiently, the agency began a new payment model in 2013 that prioritizes quality preventive care and rewards providers for reducing the cost of care for enrollees in Medical Assistance and MinnesotaCare. The traditional health care model pays providers for the volume of care they deliver rather than the quality of the care they provide. The *Integrated Health Partnerships (IHP)* initiative gives participating providers financial incentives to manage the total cost of care through better coordination of medical care and prioritizing quality preventive care. In return for reducing the total cost of care for health care enrollees, providers are eligible for a share of the savings. In the first year of the project six providers serving a total of 100,000 Minnesotans in MinnesotaCare and Medical Assistance spent $10.5 million less than projected. In 2014, three additional providers joined the project bringing the total number of enrollees in the demonstration to 145,000. Beginning in 2014, providers also share in the risk if costs are higher than projected.

This IHP, originally known as the Health Care Delivery Systems demonstration, is one of the key components of a $45 million federal State Innovation Model (SIM) grant for health care reforms. The SIM grant provides funding for a joint effort by DHS and the Department of Health to develop new ways of delivering and paying for health care and creating healthy communities using the Minnesota Accountable Health Model.

RESULTS

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	Percent of Minnesotans without health insurance[1]	8.2%	4.9%	2013 to 2014
Quality	Percent of Low-income Minnesotans without Health Insurance[2]	16.3%	15.9%	2011 to 2013
Quality	Percent of total MA and MinnesotaCare program enrollees served by an IHP[3]	12%	16%	2013 to 2014
Quality	Estimated reduction in health care spending on MHCP enrollees whose care is attributed to providers participating in the Integrated Health Partnership demonstration project[4]	N/A	$(10.5) million	2013

Performance Measure Notes:

1. Measure is the percent of Minnesotans that do not have health insurance. Source: University of Minnesota State Health Access Data Assistance Center. Compares 2013 (Previous) to 2014 (Current).
2. Measure is the percentage of Minnesotans with family income below 200% of poverty who do not have health insurance. Source: Minnesota Health Access Survey, Minnesota Department of Health. Compares 2011 (previous) and 2013 (current).
3. Measure is the percentage of Minnesota Health Care Program enrollees served by an IHP provider. Compares 2013 (Previous) and 2014 (Current).

[1] Income eligibility guidelines (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3182-ENG) and estimated premium amounts (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4139A-ENG) by income are available on the DHS web site.

4. Measure is an estimated reduction in medical expenditures below projections for 2013 for the providers enrolled in the IHP demonstration. IHP provider contracts require this measure be calculated in the same manner each year, so the agency will be able to monitor this new measure over time. The savings reflected in this measure represent reduced health care expenditures as a result of the demonstration and are shared with providers.

Minnesota Statutes, chapter 256L (https://www.revisor.mn.gov/statutes/?id=256L) provides the legal authority to operate the MinnesotaCare program. Because the federal government considers elements of MinnesotaCare to be a Medicaid waiver program, M.S. chapter 256B (https://www.revisor.mn.gov/statutes/?id=256B) is another source of legal authority for the MinnesotaCare program.

Program: Forecasted Programs
Activity: Medical Assistance

http://www.dhs.state.mn.us/main/id_006254

AT A GLANCE

- In fiscal year 2013, MA served a monthly average of 739,158 people. This is 13.6% of the state's population.
- In FY2013, basic care coverage for families with children made up 59% of total enrollment, but only 24% of total expenditures.
- In FY 2013, coverage for the elderly and disabled made up 31% of total enrollment, but 66% of total expenditures.
- In FY2013, basic care coverage for adults without children accounted for 10% of both total enrollment and total expenditures.
- 124,587 adults received mental health services through MA and MinnesotaCare in CY 2013.
- 17,589 adults received mental health case management services through MA and MinnesotaCare in CY 2013.
- MA is funded with state general funds, federal Medicaid funds, and with local shares for a few particular services. Beginning in FY2014 the state Health Care Access Fund also funds some MA spending.
- All funds spending for the Medical Assistance activity for FY 2013 was $8.3 billion. This represented 69.1% of the Department of Human Services overall budget.
- Of those FY 2013 total expenditures, the Minnesota state share was $3.8 billion.

PURPOSE & CONTEXT

Medical Assistance (MA) is Minnesota's Medicaid program. MA provides coverage for preventive and primary health care services for low-income Minnesotans. MA differs from the state's other health care program, MinnesotaCare, in that it has lower income eligibility guidelines, does not have premiums, and pays for previously incurred medical bills up to three months prior to the month of application. Additionally, MA can pay for nursing facility care and intermediate care facilities for people with developmental disabilities. It can also cover long term care services and supports for people with disabilities and older adults so that they can continue living in the community.

The Minnesota Department of Human Services (DHS) is the state Medicaid agency and partners with all 87 Minnesota counties to administer the MA program. Minnesota receives federal matching funds for MA. By accepting federal matching funds, states are subject to federal Medicaid regulations. States have some flexibility in determining what services are covered, what groups are covered, and in setting payment rates to providers.

DHS contracts with both health plans and health care providers across the state to deliver basic health care to MA enrollees.

The legislature made several changes to Medical Assistance eligibility during the 2013 session. The following changes to the program began in January 2014 and apply to people who *do not* have an aged, blind, or disabled basis of eligibility:

- Increased the income eligibility limit for adults without children from 75 percent of the federal poverty guidelines (FPG) to 133 percent ($31,720 for a family of four in 2014).
- Increased the income eligibility limit for parents and relative caretakers from 100 percent of FPG to 133 percent.
- Aligned MA income standards with federal tax rules and eliminated asset tests.
- Simplified renewal processes, requiring less information from enrollees and renewing once per year instead of every 6 months.
- Extended coverage of children in foster care until age 26.
- Increased income eligibility for children from 150 percent of FPG to 275 percent.
- Increased income eligibility for pregnant women from 275 percent of FPG to 278 percent.
- Added an income disregard equal to 5 percent of FPG to the top of the income limits for these non aged blind and disabled populations. This change raised the effective eligibility limits slightly higher than those listed in the bullets above.

Under the new income standards, people formerly eligible for MinnesotaCare, including children and pregnant women with household income up to 275 percent of poverty and adults below 133 percent of poverty, became eligible for MA. As a result of these changes, about 110,000 MinnesotaCare recipients transitioned to coverage in the MA program in January 2014.

SERVICES PROVIDED

MA enrollees fall under one of five general categories:

1. MA Coverage of Basic Health Care for Elderly and Disabled

In FY2013, this segment of MA funds supported an average of 181,743 people per month, many of whom are also enrolled in Medicare and so are "dual eligible beneficiaries." Total spending on this group was $2.1 billion in FY2013, about $1.05 billion of which came from state funds. Health coverage for this group includes most health services outside of long-term care including:

- primary and preventive care
- inpatient hospital benefits
- mental health and chemical dependency treatment
- medical transportation
- medical equipment
- prescription drugs
- dental care
- coverage for eyeglasses and eye care

People receiving these services are low-income elderly (65 years or older) and people who are blind or have a disability. Their income and assets must be below allowable limits. As MA enrollees they receive health care coverage or financial assistance to help them pay for their Medicare premiums and cost sharing/copayments. (This latter approach is often less expensive for the state than if the state provided their health coverage under MA alone.)

This segment of the MA program also includes the Medical Assistance for Employed Persons with Disabilities (MA-EPD) program. MA-EPD allows a monthly average of 8,500 working individuals with disabilities to receive the full MA benefit set. This program encourages people with disabilities to work and enjoy the benefits of being employed. It allows working people with disabilities to qualify for MA without an income limit and under higher asset limits than standard MA. More information on MA-EPD is available in the Medical Assistance for Employed Persons with Disabilities brochure (http://edocs.dhs.state.mn.us/lfserver/public/DHS-2087L-ENG).

2. MA Coverage of Care in Long-Term Care Facilities

MA pays for long-term care services for people who reside in facilities. In FY 2013, this segment of MA funds supported an average of nearly 18,000 people per month. Total spending on this group was just over $920 million in FY2013, about $470 million of which came from state funds. Care provided under this segment of MA includes 24-hour care and supervision in nursing facilities or intermediate care facilities for persons with developmental disabilities (ICF/DD). It also includes day training and habilitation (DT&H) services for people who live in an ICF/DD.

A nursing facility (also called a nursing home) provides 24-hour care and supervision in a residential facility setting. Nursing facilities provide an all-inclusive package of services that covers: nursing care, help with activities of daily living and other care needs, housing, meals and medication administration. An ICF/DD provides 24-hour care, active treatment, training and supervision to people with developmental disabilities. DT&H services help people living in an ICF/DD develop and maintain life skills, and take part in the community through productive and satisfying activities. DT&H services include supervision, training and assistance in self-care, communication, socialization, behavior management, and supported employment and work-related activities, among others.

DHS works with community providers, counties and tribes, and the Department of Health in administering and monitoring services in these long-term care settings. More information is available in a nursing home fact sheet (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5961-ENG).

To receive MA long-term care services a person must have income and assets that are below allowable limits and have an assessed need for the services.

3. MA Coverage of Care through Long-Term Care Waivers & Home Care

In Minnesota MA also pays for people to receive long-term care waiver or home care services in their homes and communities. In FY 2013, this segment of MA funds supported an average of just over 54,000 people per month. Total spending on this group was just over $2.26 billion FY2013, about $1.3 billion came from state funds. Long-term care waivers, also known as Home and Community-Based Services (HCBS) waivers, are an alternative for people who need long-term care services but who do not choose to live in a nursing facility, ICF/DD or hospital. The federal Centers for Medicare and Medicaid Services (CMS) allows states to apply for long-term care waivers which provide different kinds of services that help people live in the community instead of in a facility or institution. These waivers can offer:

- in-home, residential, medical and behavioral supports
- customized day services
- employment supports
- Consumer-Directed Community Supports (a self-directed option)
- caregiver supports
- transitional services to support people to move out of institutions or other congregate settings
- transportation
- home modifications
- case management
- other goods and services

Minnesota operates five home and community-based waivers:

- Brain Injury (BI) – for individuals with a brain injury meeting a nursing facility or neurobehavioral hospital level of care
- Community Alternative Care (CAC) – for individuals with disabilities meeting a hospital level of care
- Community Alternatives for Disabled Individuals (CADI) – for individuals with disabilities meeting a nursing facility level of care
- Developmental Disabilities (DD) – for individuals with developmental disabilities meeting an Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD) level of care
- Elderly Waiver (EW) – for individuals age 65 and older meeting a nursing facility level of care

Home care services provide a range of medical care and support services in a person's home or community. Services include assessments, home health aide visits, nurse visits, home care nursing (previously private duty nursing), personal care services, home health therapies, and medical supplies and equipment. The agency is developing a new service called Community First Services and Supports (CFSS) that will replace personal care services. CFSS will be more flexible and expand self-directed options.

4. MA Coverage of Basic Health Care for Families with Children

In FY 2013, this segment of MA funds supported an average of 471,949 people per month. Total spending on this group was just over $1.93 billion FY2013, about $950 million of which came from state funds. The covered services include:

- primary and preventive care
- inpatient hospital benefits
- mental health and chemical dependency treatment
- medical transportation
- medical equipment
- prescription drugs
- dental care
- coverage for eyeglasses and eye care

Recipients of this health care coverage are often the lowest income Minnesotans, and include low income pregnant women, children, parents and caretaker relatives.

This segment of the MA program also includes funding for the Minnesota Family Planning Program (MFPP) and the MA Breast and Cervical Cancer Treatment program (MABC). MFPP provides coverage of family planning and related health care services for people not currently enrolled in MA or MinnesotaCare. MABC covers treatment costs for breast cancer, cervical cancer or a precancerous cervical condition for women without health insurance.

5. MA Coverage of Basic Health Care for Adults without Children

In FY2013, this segment of the MA program served an average of 85,466 people per month. Total spending on this group was about $792 million in FY2013, with $385 million coming from state funds. The covered services include:

- primary and preventive care
- inpatient hospital benefits
- mental health and chemical dependency treatment
- medical transportation
- medical equipment
- prescription drugs
- dental care
- coverage for eyeglasses and eye care

A full list of Medical Assistance populations, income and asset limits is in a Minnesota Health Care Programs brochure (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3182-ENG).

INNOVATIONS UNDERWAY

DHS works with many stakeholders to determine how we can improve our health care programs. Here are some examples of how DHS is working toward program improvements:

1. Integrated Health Partnerships

As part of Minnesota's commitment to deliver quality health care more efficiently, the agency began a new payment model in 2013 that prioritizes quality preventive care and rewards providers for reducing the cost of care for enrollees in MA and MinnesotaCare programs.

The traditional healthcare model pays providers for the volume of care they deliver rather than the quality of the care they provide. The *Integrated Health Partnerships (IHP)* initiative gives participating providers financial incentives to manage the total cost of care through better coordination of medical care and prioritizing quality preventive care. In return for reducing the total cost of care for health care enrollees, providers are eligible for a share of the savings. In the first year of the project six providers serving 100,000 Minnesotans spent $10.5 million less than projected. In 2014, three additional providers joined the project bringing the total number of enrollees in the demonstration to 145,000. Beginning in 2014, providers also share in the risk if costs are higher than projected.

The IHP, originally known as the Health Care Delivery Systems demonstration, is one of the key components of a $45 million federal State Innovation Model (SIM) grant for health care reforms. The SIM grant provides funding for a joint effort by DHS and the Department of Health to develop new ways of delivering and paying for health care and creating healthy communities using the Minnesota Accountable Health Model.

2. Reform 2020

Reform 2020 is a bipartisan initiative to reform MA to better meet the challenges of rising health care costs and an aging population, while still providing Minnesotans the services they need to lead fulfilling lives. Reform 2020 modifies existing services, provides new services to targeted groups and with federal approval it allows the state to try new ways to deliver and pay for health care and long-term care services. The goal of Reform 2020 is to ensure that people receive the right services, at the right time, in the right way.

3. Integrated Care Systems Partnerships

"Dual eligible beneficiaries" are people whose health care is covered by both Medicare and MA. In September 2013, Minnesota began a new project to improve the care experience for dual eligible beneficiaries receiving services through the Minnesota Senior Health Options (MSHO) program. Health care for dual eligible beneficiaries has historically been fragmented, complex, and confusing with Medicare paying for most primary care and Medicaid paying for acute and long-term care. The *Integrated Care Systems Partnerships* project combines the financing of the managed care organizations operating the Medicare Advantage and Minnesota's MSHO programs to improve coordination between Medicare and Medicaid services and simplify an enrollee's experience. This financing platform allows for new arrangements for provider payment and delivery reforms.

RESULTS

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	Percent of seniors served by home and community-based services[1]	59.3%	68.4%	2008 to 2013
Result	Percent of people with disabilities served by home and community-based services[2]	90.7%	92.9%	2008 to 2013
Quality	Percent of Minnesotans without health insurance[3]	8.2%	4.9%	2013 to 2014
Quality	Percent of Low-income Minnesotans without Health Insurance[4]	16.3%	15.9%	2011 to 2013
Quantity	Percent of total MA and MinnesotaCare program enrollees served by an IHP[5]	12%	16%	2013 to 2014
Quality	Estimated reduction in health care spending on MHCP enrollees whose care is attributed to providers participating in the Integrated Health Partnership demonstration project[6]	N/A	$(10.5) million	2013

Performance Measure Notes:

1. This measure reflects the percentage of older adults receiving publicly-funded long-term care services who receive HCBS services through the Elderly Waiver or Alternative Care program instead of services in nursing homes. Measure compares FY 2008 and FY 2013 data. (Source: February 2014 Forecast.)

2. This is the percent of people with disabilities receiving publicly-funded long-term care services who receive HCBS services through disability waiver or home care programs instead of services in nursing homes or Intermediate Care Facilities. Measure compares FY 2008 and FY 2013 data. (Source: February 2014 Forecast.)
3. Measure is the percent of Minnesotans that do not have health insurance. Source: University of Minnesota State Health Access Data Assistance Center. Compares 2013 (Previous) to 2014 (Current)
4. Measure is the percentage of Minnesotans with family income below 200% of poverty who do not have health insurance. Source: Minnesota Health Access Survey, Minnesota Department of Health. Compares 2011 (Previous) and 2013 (Current)
5. Measure is the percentage of Minnesota Health Care Program enrollees served by an IHP provider. Compares 2013 (Previous) and 2014 (Current).
6. Measure is an estimated reduction in medical expenditures below projections for 2013 for the providers enrolled in the IHP demonstration. IHP provider contracts require this measure be calculated in the same manner each year, so the agency will be able to monitor this new measure over time. The savings reflected in this measure represent reduced health care expenditures as a result of the demonstration and are shared with providers.

Minnesota Statutes, chapter 256B (https://www.revisor.mn.gov/statutes/?id=256B) provides the legal authority for the Medical Assistance program. An example of legislative directives to improve and innovate in Medical Assistance is M.S. section 256B.021 (https://www.revisor.mn.gov/statutes/?id=256B.021,Medical Assistance Reform Waiver).

Program: Forecasted Programs
Activity: Alternative Care

http://www.dhs.state.mn.us/main/dhs16_137084

AT A GLANCE

In fiscal year 2013, the Alternative Care Program:

- Served 4,180 people;
- Averaged 2,874 enrollees each month;
- Provided an average monthly benefit of $ 771; and
- Enrolled consumers contributed a total of $1.3 million towards their cost of care.
- All funds spending for the Alternative Care activity for FY 2013 was $26.7 million. This represented 0.2% of the Department of Human Services overall budget.

In November 2013 the program became eligible for federal Medicaid financial participation through an approved waiver.

PURPOSE & CONTEXT

The Alternative Care (AC) Program is a cost-sharing program that provides certain home and community-based services for Minnesotans age 65 and over. Alternative Care services support seniors, their families, caregivers and communities to help seniors to stay in their homes and communities and avoid costly institutionalization.

The program is a cost-effective strategy to prevent or delay people from moving onto Medical Assistance-funded long term care services, such as Elderly Waiver and nursing home care. The program helps prevent the impoverishment of eligible seniors and maximizes the use of their own resources by sharing the cost of care with clients. AC is available to individuals who need the level of care provided in a nursing home but choose instead to receive services in the community, and whose income and assets would be inadequate to fund a nursing home stay for more than 135 days.

SERVICES PROVIDED

Alternative Care (AC) services are used in a person's own home. AC covers the following services: adult day services, caregiver assessment, case management, chore services, companion services, consumer-directed community supports, home health aides, home-delivered meals, homemaker services, environmental accessibility adaptations, nutrition services, personal emergency response system, personal care, respite care, skilled nursing, specialized equipment and supplies, training and support for family caregivers and transportation.

Beginning January 1, 2015, some people who have a lower level of need for long-term care services will no longer qualify to have Medical Assistance pay for nursing facility care and community-based alternatives. Starting January 1, 2015, those people will instead be served by Essential Community Support grants, which are a new targeted benefit. Essential Community Support grants cover the following services: adult day services, service coordination (case management), chore services, home delivered meals, homemaker services, personal emergency response, caregiver education/training, and community living assistance.

DHS partners with community providers, counties, tribal health groups and the Department of Health in providing and monitoring services.

The AC program is funded with state and federal money along with monthly fees paid by the person receiving services. Payments made by the state for AC services are also subject to estate recovery. Essential Community Support grants are state funded only.

Alternative Care supports the following strategy in the DHS Framework for the Future: 2014

- Increase the number of Minnesotans served in their homes and communities rather than in institutions.

More information is available on the Alternative Care fact sheet (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4720-ENG).

RESULTS

The agency monitors performance measures that show how this program is working. One key measure is how much people who are eligible for publically funded long-term care services access the services in their homes and community rather than in nursing facilities.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	1. Percent of seniors served by home and community-based services	59.3%	68.4%	2008 to 2013
Quantity	2. Percent of long-term care expenditures for seniors spent on home and community-based services	36.1%	45.1%	2008 to 2013
Quantity	3. Percent of AC spending on Consumer-Directed Community Supports (CDCS)	3.3%	5.4%	2009 to 2013

Performance Notes:

1. Measure one compares FY2008 to FY2013 data. This measure shows the percentage of elderly receiving publicly funded long-term care services who receive HCBS services through the Elderly Waiver, Alternative Care, or home care programs instead of nursing home services. Source: February 2014 Forecast.
2. Measure two compares 2008 to 2013 data. This measure shows the percentage of public long-term care funding for the elderly that is spent on Elderly Waiver, Alternative Care or home care services instead of nursing home services. Source: DHS Data Warehouse.
3. Measure three compares FY2009 to FY2013 data. CDCS gives persons more flexibility and responsibility for directing their services and supports—compared to services provided through the traditional program – including hiring and managing direct care staff. Source: DHS Data Warehouse.

More information is available on the Continuing Care Performance Report (http://www.dhs.state.mn.us/main/dhs16_166609) and the DHS Dashboard (http://dashboard.dhs.state.mn.us/).
The Alternative Care and Essential Community Support programs are authorized by Minnesota Statutes, sections 256B.0913 (https://www.revisor.mn.gov/statutes/?id=256B.0913) and 256B.0922 (https://www.revisor.mn.gov/statutes/?id=256B.0922).

Program: Forecasted Programs
Activity: CD Treatment Fund

http://mn.gov/dhs/people-we-serve/adults/health-care/substance-abuse/programs-services/ccdtf.jsp

AT A GLANCE

- In the United States, 22.2 million people age 12 and older are chemically dependent (CY2012)
- Statewide, the number of admissions into chemical dependency treatment has increased to 50,801 in 2013. The CD Treatment Fund pays for about half of these admissions for treatment.
- The percentage of people completing chemical dependency treatment dropped to 53.6% in 2013.
- All funds spending for the CD Treatment Fund activity for FY 2013 was $140.4 million. This represented 1.2% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The CD Treatment Fund activity pays for residential and outpatient chemical dependency (CD) treatment services for eligible low-income Minnesotans.

People access the chemical dependency treatment services paid by the Fund by first being assessed as needing treatment for chemical abuse or dependency, and second by meeting financial eligibility guidelines. If a person is determined to have both a clinical need for treatment and is financially eligible for the CD Treatment Fund, then the Fund can pay for their CD treatment services.

Counties and tribes are responsible for providing assessments (known as "Rule 25" assessments) to individuals seeking access to these funds. These assessments not only determine an individual's eligibility for the Fund but also determine the appropriate level or intensity of services the person may need based on their condition and circumstances.

SERVICES PROVIDED

The Consolidated Chemical Dependency Treatment Fund is the single fee-for-service public payment source that funds residential and outpatient chemical dependency treatment services for eligible low-income Minnesotans. The CCDTF combines multiple funding sources – Medical Assistance, MinnesotaCare, other state appropriations and the federal Substance Abuse, Prevention and Treatment block grant – into a single fund with common eligibility criteria and a single process for evaluating treatment need and placement options. Federal Medicaid matching funds are collected on the treatment services provided to Medical Assistance recipients. Counties also contribute a share toward the cost of treatment. Counties pay 15 percent of treatment costs for Medical Assistance (MA) recipients and 22.95 percent for non-MA recipients. The CCDTF pays for services that are part of a licensed residential or non-residential CD treatment program. The CCDTF ensures that all clients have the same access to high quality, effective treatment programs.

All of these programs provide a continuum of effective, research-based treatment services for individuals who need them. Treatment services include individual and group therapy in outpatient or residential settings, and may also include treatment for a mental illness, other medical services, medication-assisted therapies (with or without adjunct behavioral services), and service coordination.

CD treatment providers use a variety of evidence-based practices, such as the twelve-step facilitation program, cognitive behavioral therapies, specialized behavioral therapy, motivational interviewing and motivational enhancement therapy as methods to ensure success.

RESULTS

Type of Measure	*Name of Measure*	*Previous (CY2012)*	*Current (CY2013)*	*Dates*
Quantity	Number of treatment admissions to chemical dependency treatment[1]	50,124	50,801	2012 to 2013
Result	Percent of persons completing chemical dependency treatment	56%	53.6%	2012 to 2013
Result	Reduction from admission to discharge of the percent of clients who report use of alcohol in the past 30 days.	30.10%	27.8%	2012 to 2013
Result	The Reduction from admission to discharge measure is the change in percent of clients who reported alcohol use within the last 30 days at time of admission and then again at the time of discharge	Admit 43.5% Discharge 13.3%	Admit 41.2% Discharge 13.4%	2012 to 2013 2012 to 2013

Measure Notes:

1. This indicator is from the Drug and Alcohol Abuse Normative Evaluation System (DAANES) in the Performance Measurement & Quality Improvement section in the Alcohol and Drug Abuse Division of the Minnesota Department of Human Services.

Minnesota Statutes chapter 254B (https://www.revisor.mn.gov/statutes/?id=254B) provides the legal authority for the CD Treatment Fund. M.S. section 254B.01, Subd.3 (https://www.revisor.mn.gov/statutes/?id=254B.01) defines chemical dependency services payable by the CD Treatment Fund. This definition applies to a wide variety of services within a planned program of care to treat a person's chemical dependency.

Program: Grant Programs
Activity: Support Services Grants

MFIP/DWP (http://www.dhs.state.mn.us/main/id_004112)
SNAP E&T (http://www.dhs.state.mn.us/main/id_002556)

AT A GLANCE

- Provides MFIP/DWP employment services to approximately 28,000 people per month.
- Provides Supplemental Nutrition Assistance Program employment services to approximately 450 people per month.
- All funds spending for the Support Services Grants activity for FY 2013 was $104.6 million. This represented 0.9% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The Minnesota Family Investment Program (MFIP) and Diversionary Work Program (DWP) primary focus is on work, by building on job placements in today's economy and focusing on future workforce development.

Support Services Grants cover costs of services to create pathways to employment by addressing barriers, helping stabilize families and adults, and building skills that ensure participants are prepared to find and retain employment.

These grants ensure that a foundation is there to deliver key activities to help families meet their basic needs and achieve their highest potential.

SERVICES PROVIDED

The Support Services Grants activity provides funding for the MFIP Consolidated Fund. Counties and tribes use the MFIP Consolidated Fund to provide an array of employment services including job search, job placement, training and education. The Consolidated Fund also provides other supports such as emergency needs for low-income families with children.

The Support Services Grants activity also provides funding for employment supports for adults who receive benefits through the Supplemental Nutrition Assistance Program (SNAP), or the SNAP Employment and Training program.

Services are delivered by Workforce Centers, counties, tribes and community agencies. Service providers evaluate the needs of each participant and develop an individualized employment plan that builds on strengths and addresses areas of need. Services include:

- Referrals to housing, child care, and health care coverage, including any needed chemical and mental health services, to aid in stabilizing families
- Basic education, English proficiency training, skill building and education programs to prepare participants for the labor market
- Job search assistance and job placement services to help participants locate employment that matches their skills and abilities
- Innovative programs to address special populations or needs such as: a single point of contact for teen parents that includes public health home visits, subsidized work experiences, integrated services for families with serious disabilities and support for the FastTRAC program, which links education and credentials to high demand careers.

Support Services Grants also fund a portion of counties' costs to administer MFIP and DWP. Support Services Grants are allocated to counties and tribes, and are funded with a combination of state and federal funds, including from the federal Temporary Assistance for Needy Families block grant.

RESULTS

The two key measures in MFIP/DWP are:

- The Self-Support Index (S-SI), which is a results measure. The S-SI shows the percentage of adults eligible for MFIP or DWP in a quarter who have left assistance or are working at least 30 hours per week three years later. Customized targets are set for each county or tribe using characteristics of the people served and local economic conditions. State law requires the Department of Human Services to use the Self-Support Index to allocate performance bonus funds. The chart following shows

that about two-thirds of participants have left MFIP or DWP and/or are working at least 30 hours per week three years after a baseline period.

Year ending in March of:	S-SI
2008	71.8%
2009	68.9%
2010	67.0%
2011	65.2%
2012	65.3%
2013	66.9%
2014	68.5%

- The federal Work Participation Rate (WPR), which is a measure of quantity. The WPR shows parents engaging in work and specific work-related activities. We calculate an estimated WPR for counties, county consortiums and tribes monthly, and it is annualized to allocate performance bonus funds. (Beginning in calendar year 2016, the bonus will be based solely on the S-SI.) The chart following shows the WPR for 2008 to 2013.

Calendar Year	WPR
2008	29.9%
2009	29.8%
2010	40.2%
2011	43.9%
2012*	45.3%
2013*	45.1%

*State estimate (Federal figures not yet released)

Another employment-related, state-mandated performance measure tracked is:

- MFIP/DWP Median Placement Wage, a quality measure that reflects the number of people getting jobs and the median wage. The chart shows the statewide median hourly starting wage. (Tribes are not included.)

Calendar Year	Median Placement Wage Per Hour for MFIP Clients	Median Placement Wage Per Hour for DWP Clients
2008	$8.38	$8.92
2009	$8.50	$9.00
2010	$8.98	$9.19
2011	$8.95	$9.27
2012	$9.00	$9.58
2013	$9.18	$9.84

The legal authority for Support Services Grants is M.S. sections 256J.626 (https://www.revisor.mn.gov/statutes/?id=256J.626) and 256D.051 (https://www.revisor.mn.gov/statutes/?id=256D.051)

The statutory requirement for a quarterly comparison report, "MFIP Management Indicators Report," is in M.S. sec. 256J.751 (https://www.revisor.mn.gov/statutes/?id=256J.751)

Program: Grant Programs
Activity: BSF Child Care Assistance Grants

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008688#

AT A GLANCE

- In 2013 Basic Sliding Fee Child Care Assistance paid for child care for 15,538 children in 8,609 families in an average month.
- As of June, 2014 there was a waiting list of 6,679 families eligible for assistance, but who could not be served at the current funding levels.
- The average monthly assistance per family was $811
- All funds spending for the BSF Child Care Assistance Grants activity for FY 2013 was $84.7 million. This represented 0.7% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

A 2009 study commissioned by the Department of Human Services and conducted by Wilder Research found that about three quarters of Minnesota households with children ages 12 and younger use child care. These families are challenged to find affordable child care that fits their preferences and needs. In households with low incomes, 20 percent of parents reported that child care problems interfered with their getting or keeping a job in the past year. Without this program, many low-income families would not be able to pay for child care and would be unable to work or pursue education leading to work.

Basic Sliding Fee (BSF) Child Care Assistance Grants provide financial subsidies to help low-income families who do not participate in the Minnesota Family Investment Program or the Diversionary Work Program. The grants help pay for child care so that parents may pursue employment or education leading to employment, and children are well cared for and prepared to enter school ready to learn.

Families earning no more than 47 percent of the state median income ($34,459 in 2013 for a family of three) are eligible to enter the Basic Sliding Fee program.

SERVICES PROVIDED

BSF child care assistance grants provide support to help improve outcomes for the most at-risk children and their families by increasing access to high quality child care.

Families must be working, looking for work or attending school to be eligible for the Basic Sliding Fee Program. The program helps families pay child care costs on a sliding fee basis. As family income increases, so does the amount of child care expenses (copayment) paid by the family. All families receiving child care assistance and earning 75 percent or more of the federal poverty guideline make copayments based on their income. A family of three earning 55 percent of the state median income ($40,325) would have a total biweekly child care payment of $130 for all children in care.

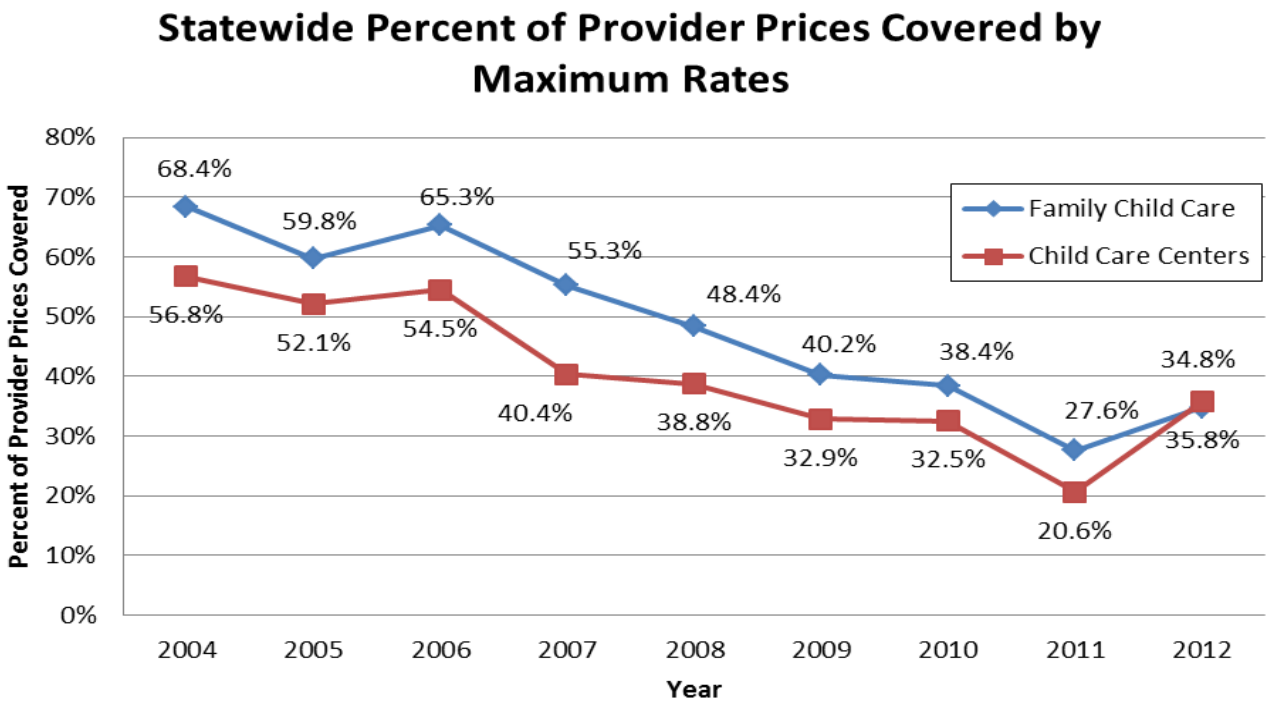
The BSF child care assistance grants activity is part of the state's Child Care Assistance Program. Maximum rates in the Child Care Assistance Program are set in state law. Maximum rates are set for each type of care: child care centers, family child care and legal non-licensed child care. The program pays providers at the rate they charge in the private child care market, up to the maximum rate. The program pays a higher rate to child care providers who provide high quality child care. Participation in high quality care increases the likelihood of children's improved school readiness.

Child care must be provided by a legal child care provider over the age of 18 years. Allowable providers include legal nonlicensed family child care, license-exempt centers, licensed family child care and licensed child care centers. Families choose their providers in the private child care market. Counties administer the Child Care Assistance Program.

BSF funding is a capped allocation. It includes a combination of state funds and federal Child Care and Development and Temporary Assistance for Needy Families funding. The agency allocates funding to counties, who administer the program. Because the funding is capped, not everyone who is eligible for the program may be served. As of June 2014, there was a waiting list for BSF child care assistance of 6,679 families.

Maximum rates paid to providers under the Child Care Assistance Program may not cover the full cost of child care. This may be a barrier for some families who cannot find a provider in their community whose rates are covered by the maximum allowed under the program. The percent of child care provider rates that are fully covered by the Child Care Assistance Program increased when the maximum rates were raised in 2014, but the maximum rates remain low compared to rates in the market.

This quality measure shows approximately 35% of child care providers charge rates that are fully covered by the Child Care Assistance Program maximum rates.

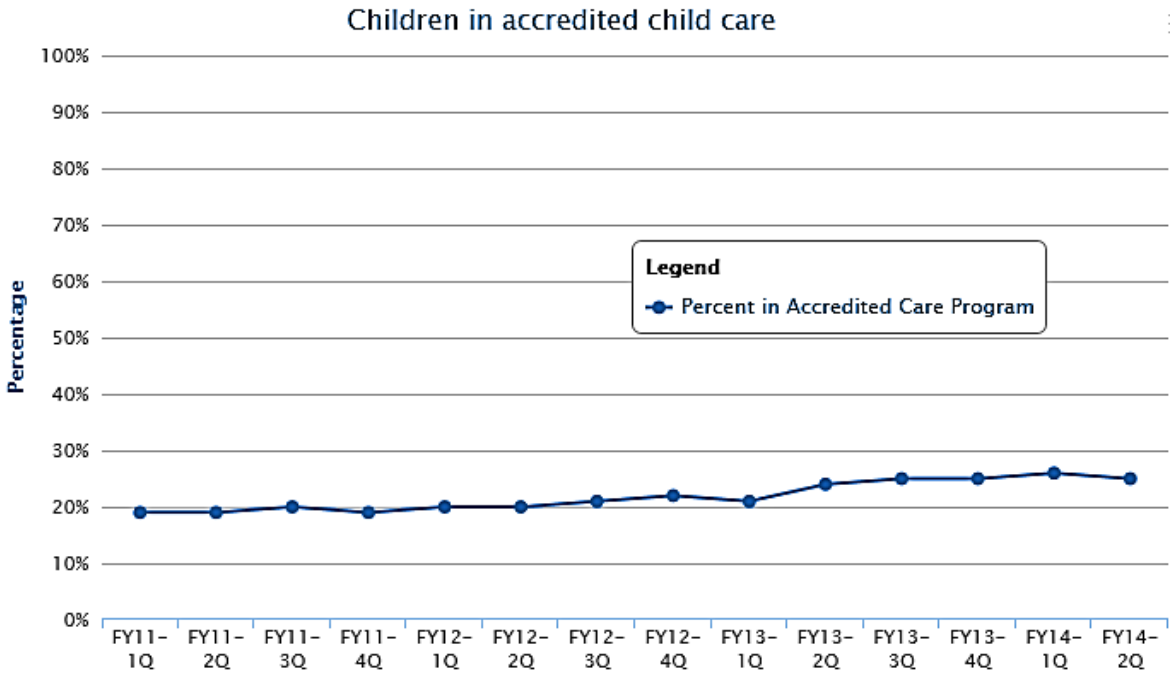


High quality early child care and education experiences are associated with better outcomes, particularly for children from low-income families. Parent Aware is Minnesota's rating tool for helping parents select high quality child care and early education programs.

Beginning in March 2014, the Child Care Assistance Program pays a rate increase to providers with higher ratings:

- Up to a 15 percent higher maximum rate is paid to providers with a Parent Aware three-star rating, or who meet certain accreditation or education standards established in statute.
- Up to a 20 percent higher maximum rate is paid to providers with a four-star Parent Aware rating.

Another quality measure, *Children in Accredited Child Care*, shows an increase over time in the percent of children served by the Child Care Assistance Program receiving care from a provider who met quality standards through an accredited child care program.



The data source for the percent of providers covered by maximum rates is a survey of provider prices conducted by the Department and used to determine the percent of providers who are covered by maximum rates.

The data source for children in accredited care is from MEC2, Minnesota's child care electronic eligibility and payment system.

The legal authority for the Basic Sliding Fee (BSF) Child Care Assistance program is in M.S. chapter 119B. (https://www.revisor.mn.gov/statutes/?id=119B)

Program: Grant Programs
Activity: Child Care Development Grants

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008689

AT A GLANCE

- As of July 2014, more than 1600 child care and early education programs have a Parent Aware rating.
- More than 18,900 parents received help in locating and choosing child care.
- Eighty-seven child care centers and six family child care providers received financial support to earn a nationally-recognized accreditation.
- All funds spending for the Child Care Development Grants activity for FY 2013 was $13.4 million. This represented 0.1% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Child Care Development Grants are used for services that promote children's development and learning.

It is important that all children and their families have access to high quality child care and early education programs. The first few years of children's lives are key to their intellectual, emotional and social development. Everyone wants to know that children are being well cared for while family members are at work or school. High quality child care that is available and affordable is important to children's safety and healthy development, and to families' self-sufficiency.

Child Care Development Grants provide support for services and initiatives that increase the availability of quality care and education in Minnesota.

These grants also support Parent Aware, Minnesota's rating tool for selecting high quality child care and early education programs. This system helps parents find high quality child care and early education programs to prepare their children for kindergarten.

SERVICES PROVIDED

The Department of Human Services (DHS) works with public and private agencies and individuals to promote school readiness through education and training. Child Care Development Grants are used to support services that improve the quality of early childhood and school- age care, and increase access to high quality care, especially for high-needs children. This grant activity also supports consumer education services for parents searching for child care. Services support:

- Information for parents searching for quality child care and early education for their children through Parent Aware, an online search tool (Parent Aware Ratings website, http://parentawareratings.org/), and other parent education services provided by Child Care Aware of Minnesota
- Grants, financial supports and other incentives for child care programs to improve quality, including for those participating in the voluntary Parent Aware Quality Rating and Improvement System
- Training, coaching, consultation and other workforce supports for early childhood and school-age care providers to increase their knowledge and skills in child development, instructional practices and ways to meet the needs of individual children
- Reimbursement to child care programs and providers to cover some of the fees charged to complete a nationally recognized child care accreditation program

Child Care Development Grants are funded primarily with federal Child Care and Development block grant funds, with additional federal support from Minnesota's Race to the Top-Early Learning Challenge grant and some state funds.

RESULTS

Beginning in March 2014, child care providers with higher Parent Aware ratings receive a payment rate increase for children in their care who receive Child Care Assistance. The increase in the number of programs receiving a Parent Aware rating and reimbursement for accreditation fees indicates improvement in the availability of quality early learning programs.

The decrease in the number of parents who receive help in choosing child care from Child Care Resource and Referral agencies may indicate parents need a better tool to help choose quality child care. A new and improved website for parents is being launched in FY2015 to better meet parents' needs in choosing child care.

Type of Measure	*Description*	*Previous*	*Current*	*Dates*
Quantity	Child care and early education programs with a Parent Aware rating[1]	8 percent	13 percent	2013 & 2014
Quantity	Number of child care centers receiving reimbursement for accreditation fees[3]	14 percent	25 percent	2013 & 2014
Quantity	Number of family child care programs receiving reimbursement for accreditation fees[2]	21 percent	25 percent	2013 & 2014
Quantity	Referrals to parents from Child Care Resource & Referral agencies[2]	20,442	18,936	2013 & 2014

Performance Measures notes:

1. Data is tracked by DHS and includes licensed child care programs, Head Start sites and school-based pre-kindergarten sites.

2. Data is collected by Child Care Aware and includes phone and internet contacts with parents.

3. Data is tracked by DHS. Family child care and center-based programs are reimbursed for half the direct cost of accreditation fees, upon successful completion of accreditation with a nationally recognized child care accreditation program.

The legal authority for the Child Care Development Grant activities is M.S. chapter 119B (https://www.revisor.mn.gov/statutes/?id=119B).

Program: Grant Programs
Activity: Child Support Enforcement Grants

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000160

AT A GLANCE

- County and state child support offices provide services to more than 398,000 custodial and non-custodial parents and their 270,000 children.
- In 2013, the child support program collected and disbursed $604 million in child support.
- Access and visitation funds served 478 families in 2013.
- All Funds spending for the Child Support Enforcement Grants Activity for FY 2013 was $1.7 million dollars. This represented 0.01% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Every child needs financial and emotional support, and every child has the right to support from both parents. Minnesota's child support program benefits children by enforcing parental responsibility for their support.

According to the *Federal Office of Child Support Enforcement FY2013 Preliminary Report,* in the United States the child support program served 17 million or nearly one in four children in 2013. Across the nation state and tribal child support programs collected $32 billion in child support.

Child support represents a high proportion of income for low income custodial parents. 29 percent of custodial parent families eligible for child support have income below the federal poverty level. For low-income families who receive child support, the average amount received represents 52 percent of their income. 82 percent of custodial parents who are eligible for child support are women, 79 percent are 30 years-old or older, and 57 percent have just one eligible child.

Child Support Enforcement Grants help strengthen families by providing financial supports. Child support helps families become self-sufficient.

SERVICES PROVIDED

Under state direction and supervision, child support activities are administered by counties and tribes. Staff provides assistance in obtaining basic support, medical support and child care support for children, through locating parents and establishing paternity and support obligations. Without this assistance, many families would not have the financial resources to remain self-sufficient.

The following activities help to support and stabilize families:

- Establish paternity through genetic testing, Recognition of Parentage or other means;
- Establish and modify court orders for child support, medical support and child care support, based on statutory guidelines;
- Enforce court orders to assure payment through remedies established in federal regulation and state law, such as income withholding, driver's license suspension and passport denial; and,
- Collect and process payments from employers, parents, counties and other states, and issue support funds to families.

Additional grants provide federal funding to improve non-custodial parents' access to their children. Funding is a mix of federal funds, state general funds and fees.

RESULTS

The federal government funds state child support programs in part through performance incentives. These are calculated by measuring the state's performance in core activities: Paternity establishment, order establishment, collection of current support, collection of arrears (past due support) and program cost effectiveness. States are ranked by their scores on the measures and earn higher incentives as performance increases. Each percentage measurement has a threshold of 80 percent to earn the maximum incentive for that measure. To maximize the incentive for cost-effectiveness, states must collect $5.00 for every dollar spent on the child support program.

Minnesota's child support performance has increased in all measures over the last five years. Minnesota ranks among the top five states on child support collections measures. In 2013, Minnesota earned $12 million dollars in federal incentives. The federal incentives are passed on to counties to help cover their administrative costs of the program.

Type of Measure	Performance Measures1	FFY2 2013	FFY 2012	FFY 2011	FFY 2010	FFY 2009
Quantity	Paternities established3: percent of children born outside marriage for whom paternity was established in open child support cases for the year	102%	102%	101%	100%	99%
Quantity	Orders established: percent of cases open at the end of the year with orders established	86%	86%	86%	85%	84%
Quantity	Collections on current support: percent of cases with current support due within the year that had a collection on current support	71%	71%	70%	69%	70%
Quantity	Collections on arrears: percent of cases with arrears due within the year that had a collection on arrears	70%	70%	70%	70%	67%
Quality	Cost effectiveness: dollars collected per dollar spent	$3.63	$3.51	$3.59	$3.70	$3.71

Performance Measures notes:

1. Federal performance measures are listed in the 2013 Minnesota Child Support Performance Report. (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4252N-ENG.)
2. FFY = federal fiscal year
3. Paternities established can be higher than 100 percent because the results include children born in prior years for whom paternity has been established in that year.

The legal authority for Child Support Enforcement Grants comes from federal and state laws.

Federal law 42 U.S.C. secs. 651-669b requires that states establish a child support program and gives general guidelines for administering the program. (Title 42 651) (http://www.gpo.gov/fdsys/pkg/USCODE-2012-title42/pdf/USCODE-2012-title42-chap7-subchapIV-partD.pdf)

State law:
Requires a person receiving public assistance to assign child support rights to the state and cooperate with child support services (M.S. sec. 256.741, https://www.revisor.mn.gov/statutes/?id=256.741)
Provides legal authority to establish child support (M.S. sec. 256.87, https://www.revisor.mn.gov/statutes/?id=256.87) and to establish paternity (M.S. sec. 257.57, https://www.revisor.mn.gov/statutes/?id=257.57)
Provides legal authority to set and collect fees for child support services (M.S. sec. 518A.51, https://www.revisor.mn.gov/statutes/?id=518A.51), and requires the state to establish a central collections unit (M.S. sec. 518A.56, https://www.revisor.mn.gov/statutes/?id=518A.56).

Program: Grant Programs
Activity: Children's Services Grants

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000152

AT A GLANCE

In 2013:

- 19,602 reports of child abuse and neglect were assessed involving 28,102 children
- Of these, 4,346 children were determined to be victims of child maltreatment
- 11,510 children experienced an out-of-home placement
- All funds spending for the Children's Services Grants activity for FY 2013 was $23.3 million. This represented 0.2% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Having strong families and communities is an effective first line of defense for keeping children safe, especially in times of stress. Children who have been abused and neglected are more likely to perform poorly in school, get involved in criminal activities and abuse or neglect their own children.

Programs and services that cultivate the factors shared by strong families and communities actually minimize long- term intervention costs for crime, corrections, truancy, hospitalization, special education and mental health care.

Research provides compelling evidence that strength- based child welfare interventions such as those funded with Children's Services Grants, result in safer children and more stable families. Without these services, children and families remain at risk.

SERVICES PROVIDED

The Children's Services Grants activity funds child welfare services around the state, including Indian child welfare services, child protection, homeless youth services, and child abuse and neglect services through counties, tribes, and community- based providers. Grants provide supports to help keep more children out of foster care and safely with their families, and to decrease the disproportionate number of children of color in out-of-home placements. Most recently these grants have been used to:

- Reform the child welfare system to focus on ensuring children's safety while supporting families
- Improve the Minnesota Child Welfare Training System
- Work with tribes to design and develop tribal approaches that ensure child safety and permanency
- Transfer responsibilities from counties to tribes to deliver a full continuum of child welfare services to American Indian children and families on two reservations
- Expand the Parent Support Outreach Program (PSOP https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4472A-ENG) by doubling the number of counties in the program.

These services are essential in keeping children safe and families stable. Children's Services Grants include state and federal funding for child welfare services.

RESULTS

The Department of Human Services monitors the performance of counties and tribes in delivering child welfare services. Minnesota outcomes match or exceed most federal standards. Efforts to engage families early and collaboratively with evidence-based interventions have resulted in improving safety and timely permanency outcomes.

Program: Grant Programs
Activity: Child & Community Service Grants

Child Protection:
(http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000152)
Adult Protective Services Unit:
(http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_005710)

AT A GLANCE

Child and Community Services Grants serve more than 213,000 Minnesotans annually. In 2013:

- 19,602 reports of child abuse and neglect were assessed involving 28,102 children
- Of these, 4,346 children were determined to be victims of child maltreatment
- 11,510 children experienced an out-of-home placement
- 1,076 children were either adopted or had a permanent transfer of legal custody to a relative
- 34,662 reports of suspected maltreatment of a vulnerable adult were received, screened and dispatched
- 13,275 reports of suspected maltreatment of a vulnerable adult were assessed by a county
- 5,132 reports of suspected maltreatment of a vulnerable adult were investigated by a county
- All funds spending for the Children & Community Services activity for FY 2013 was $85.7million. This represented 0.7% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Under the state Vulnerable Children and Adult Act, Child and Community Services Grants provide funding to support core safety services for vulnerable children and adults, including response to reports of maltreatment, assessments of safety and risk, case management and other supportive services that help keep children and adults safely in their own homes.

The grants provide funding that support counties' administrative responsibility for child protection services and foster care. The funding also helps counties to purchase or provide these services for children, vulnerable adults and families.

SERVICES PROVIDED

Funding through these grants provides core safety services that focus on preventing or remedying vulnerable adult maltreatment and child neglect, preserving and rehabilitating families, and providing for community-based care. Services include:

- Response to reports of child and adult maltreatment, and assessment of safety and risk of harm
- Adoption and foster care supports for children
- Case management and counseling.

Children and Community Services Grants provide child protection services to help keep more children out of foster care and safely with their families, and to decrease the disproportionate number of children of color in out-of-home placements. They help ensure that vulnerable children and adults are better protected and receive support services in their communities.

Allocated to counties through the state's Vulnerable Children and Adult Act, these grants include state funds and the federal Social Services Block Grant.

RESULTS

The Department of Human Services monitors the performance of counties in delivering child welfare and adult protective services. Minnesota outcomes match or exceed most federal child welfare standards. Efforts to engage families early and collaboratively with evidence-based interventions have resulted in improving safety and timely permanency outcomes for children.

Type of Measure	*Name of Measure*	*2010*	*2011*	*2012*	*2013*
Quality	Percent of children not experiencing repeated abuse or neglect within six months of a prior report	95.1%	95.6%	97.5%	97.2%
Quality	Percent of children reunified with parents or living with relatives in fewer than 12 months from latest removal from home	84.5%	85.7%	85.9%	85.1%
Quality	Percent of children adopted in fewer than 24 months from latest removal from home	48.2%	48.1%	49.4%	54.7%
Quantity	Timeliness of vulnerable adult maltreatment reports forwarded to the lead agency within two working days	92.7%	92.3%	94.4%	94%

Performance Measures notes

Measures for children in the above table are from Minnesota's Child Welfare Reports, 2010-2013. Child Protection statistical reports are posted on the DHS Child Protection Publications page (http://www.dhs.state.mn.us/main/id_003712). Also see the DHS Child Welfare Data Dashboard (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_148137http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_148137).
Measures for adults are from the Minnesota Department of Human Services Dashboard: http://dashboard.dhs.state.mn.us/measure01-2-4.aspx (http://dashboard.dhs.state.mn.us/measure01-2-4.aspx).

The legal authority for the Vulnerable Children and Adult Act is in M.S. chapter 256M (https://www.revisor.mn.gov/statutes/?id=256M). This Act establishes a fund to address the needs of vulnerable children and adults in each county under a service plan agreed to by each county board and the commissioner of human services.

Type of Measure	*Description of Measure*	*2010*	*2011*	*2012*	*2013*
Quality	Percent of children not experiencing repeated abuse or neglect within six months of a prior report	95.1%	95.6%	97.5%	97.2%
Quality	Percent of children reunified with parents or living with relatives in fewer than 12 months from latest removal from home	84.5%	85.7%	85.9%	85.1%
Quality	Percent of children adopted in fewer than 24 months from latest removal from home	48.2%	48.1%	49.4%	54.7%

Performance Measures notes:

All measures are from Minnesota's Child Welfare Reports, 2010-2013. Child Protection statistical reports are posted on the DHS Child Protection Publications page (http://www.dhs.state.mn.us/main/id_003712).

Also see the DHS Child Welfare Dashboard (http://www.dhs.state.mn.us/main/id_148137).

Several state statutes provide the legal authority for the Children's Services Grants activity:
Provisions for reasonable efforts, Interstate Compact on Placement of Children and Minnesota Indian Preservation Act are in M.S. chapter 260 (https://www.revisor.mn.gov/statutes/?id=260)
Provisions for juvenile protection are in M.S. chapter 260C (https://www.revisor.mn.gov/statutes/?id=260C)
Provisions for voluntary foster care for treatment are in M.S. chapter 260D (https://www.revisor.mn.gov/statutes/?id=260D)
Reporting of Maltreatment of minors is under M.S. section 626.556 (https://www.revisor.mn.gov/statutes/?id=626.55)

Program: Grant Programs
Activity: Child & Economic Support Grants

Activity Website: SNAP (http://www.dhs.state.mn.us/main/id_002555)
Activity Website: Economic Opportunity (http://www.dhs.state.mn.us/main/id_002550)

AT A GLANCE

Annually:

- More than 500,000 Minnesotans receive help through the Supplemental Nutrition Assistance Program (SNAP) every month; the average monthly benefit is $107 per person.
- More than 17,700 people receive emergency shelter and services with state and federal funds.
- More than 2,900 individuals in 1,300 households receive transitional housing services and more than 3,300 individuals at risk of or experiencing long-term homelessness receive supportive services.
- Funding for Community Action Agencies helped over 588,000 Minnesotans become more economically secure.

Also:

- Since 2000, Family Assets for Independence in Minnesota (FAIM) has helped people save nearly $2.9 million and acquire over 2,100 long-term financial assets.
- All funds spending for the Child & Economic Support Grants activity for FY 2013 was $625.3 million. This represented 5.2% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

People living in poverty often face numerous barriers and have complex needs. Through the Children and Economic Support Grants activity the Department of Human Services funds efforts to stabilize both short-term crises and long term strategies to help people leave poverty and sustain financial security for themselves and their families.

Through this budget activity we administer nearly 200 grants annually to more than 100 organizations to help people in poverty meet their basic needs for food, clothing and shelter. Funds are also used to help people get the skills, knowledge and motivation to become more self-reliant. Without these funds, more people would be hungry, homeless and poor.

The largest part of this budget activity is federal funding for the Supplemental Nutrition Assistance Program (SNAP). Outreach and nutrition education are conducted under this activity. These efforts help keep more people fed and healthy, and increase nutrition assistance participation.

SERVICES PROVIDED

Children and Economic Support Grants fund food, housing, poverty reduction, and financial capability services for low-income families and individuals. Services include:

- Help for low income persons to purchase food and associated outreach and education activities funded through the federal SNAP program.
- Help under the Minnesota Food Assistance Program (MFAP) for legal non-citizens who do not qualify for federal SNAP due to citizenship status
- Funding for food banks, food shelves and on-site meal programs
- Help for homeless individuals and families to find safe and stable housing
- Supportive services for people who experience long-term homelessness
- Emergency shelter and essential services for homeless adults, children, and youth
- Specialized emergency shelter and services for youth who have been victims of sex trafficking
- Funding, training, and technical assistance to counties and tribes for services to reduce barriers for long-term homeless adults, youth and families.

These grants also support:

- Programs administered by regional Community Action Agencies that help low-income people become more economically secure
- Financial capability services through the Family Assets for Independence in Minnesota (FAIM) and related financial education initiatives.

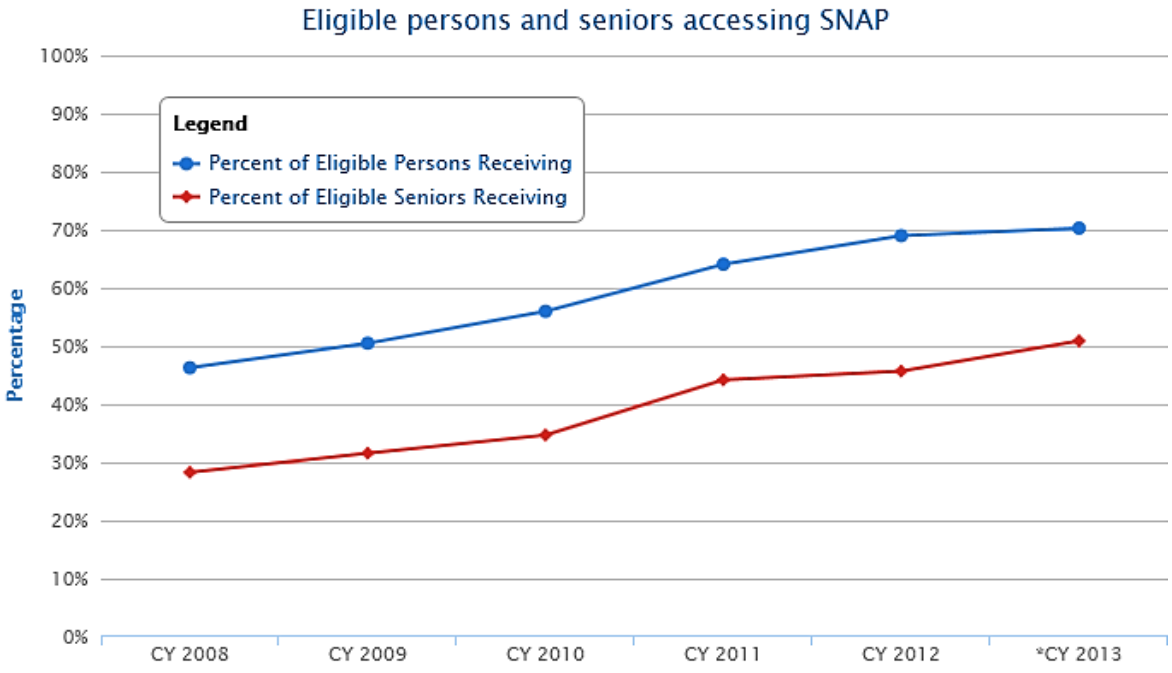
In addition to the federal funding for SNAP, other funding sources include state grants and federal grants from the U.S. Departments of Agriculture (USDA), Health and Human Services (HHS), Housing and Urban Development (HUD) as well as private foundations.

RESULTS

Several programs, such as SNAP, emergency food help, and MFAP, help people with their food needs.

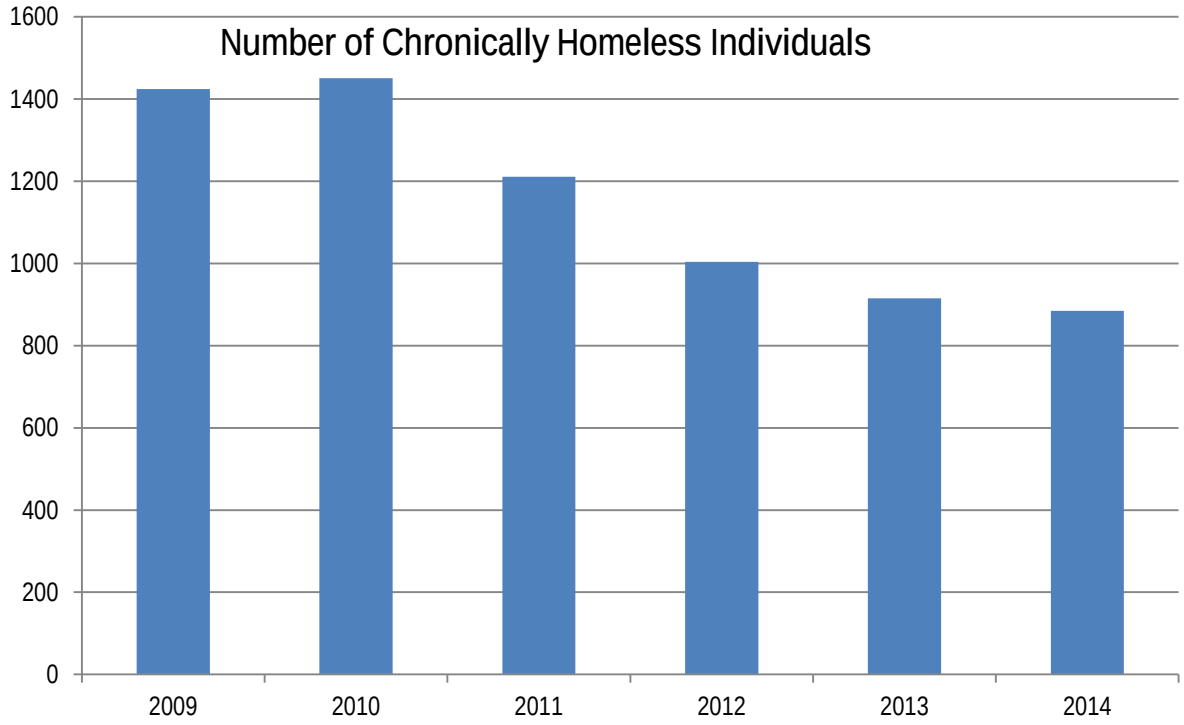
SNAP Participation Rate

The quality measure below shows increased participation in SNAP to help keep people fed and healthy.



Reducing the number of people who are chronically homeless

This quantity measure shows that the number of chronically homeless individuals has declined by 38 percent since 2009. The Long-term Homeless Supportive Services Fund assists long term and chronically homeless people to obtain and remain in housing. Reduction of the number of chronically homeless people is a goal of the *2014 Plan to End Homelessness in Minnesota*.



The legal authority for the Children and Economic Support Grants activities comes from:

Minnesota Food Assistance Program, M.S. sec. 256D.053 (https://www.revisor.mn.gov/statutes/?id=256D.053)
Community Action Programs, M.S. secs. 256E.30 to 256E.32 (https://www.revisor.mn.gov/statutes/?id=256E.30)
Transitional Housing Programs, M.S. sec. 256E.33 (https://www.revisor.mn.gov/statutes/?id=256E.33)
Minnesota Food Shelf Program, M.S. sec. 256E.34 (https://www.revisor.mn.gov/statutes/?id=256E.34)
Family Assets for Independence in Minnesota (FAIM), M.S. sec. 256E.35 (https://www.revisor.mn.gov/statutes/?id=256E.35)
Emergency Services Grants, M.S. sec. 256E.36 (https://www.revisor.mn.gov/statutes/?id=256E.36)
Homeless Youth Act, M.S. sec. 256K.45 (https://www.revisor.mn.gov/statutes/?id=256k.45)

Program: Grant Programs
Activity: Refugee Services Grants

http://www.dhs.state.mn.us/main/id_004115

AT A GLANCE

- In 2013, an average of 548 people per month received employment and social services through Refugee Services grants
- The average monthly cost per recipient in 2012 was $450 for employment-related services such as assessment, employment development planning, supported job search, placement and follow-up services.
- All funds spending for the Refugee Services Grants activity for FY 2013 was $5.0 million. This represented 0.04% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Refugees have had to flee their country of origin and are unable to return because of a well-founded fear of persecution. When no other options exist, the United States, as well as most Western nations, provides refugees an opportunity for permanent resettlement. Most refugees resettled in Minnesota over the last decade have been from Somalia, Burma, Laos, Ethiopia, Liberia, Bhutan, Iraq and Moldova.

Refugee Services Grants provide assistance to refugees, asylees and victims of human trafficking to resettle in Minnesota. These federally-funded grants are provided to state and local agencies, including county and voluntary resettlement agencies, school districts and community agencies to enhance human, health, educational, employment and training services. Absent these services, fewer refugees will find work and more will lack the medical, social and financial supports necessary to resettle successfully.

SERVICES PROVIDED

The Department of Human Services (DHS) refugee Resettlement Programs Office coordinates services to help refugees transition to life in the United States. These services may include: resettlement and placement; food, cash and health care assistance; employment services; or social services.

Most refugees who resettle in Minnesota are members of families with minor children who qualify for the same cash (Minnesota Family Investment Program) and health care programs available to state residents who have low incomes. Refugees who do not qualify for one or both of these programs can apply for Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA). These programs are available for the first eight months after refugees arrive in Minnesota. Applications for these programs are taken at county human services agencies and at voluntary resettlement agencies for refugees in the Twin Cities metro area and Olmsted County.

In addition, Refugee Services Grants provide support for an array of services, including:

- Information and referral
- Translation and interpreter services
- Case management services
- Citizenship and naturalization preparation services
- Supported employment services and transportation.

Grants are used in partnerships with local voluntary resettlement agencies, the Minnesota Departments of Health and Education, providers and refugee communities. They support services that improve refugees' health, safety and stability during resettlement.

The activity is funded with federal grants from the United States Department of Health and Human Services

RESULTS

The DHS Resettlement Programs Office uses several client outcome indicators to measure performance and determine the effectiveness of our grant management activity.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Results	Percent of refugees employed within one year of enrollment	55%	66%	Sept.2012 Sept 2013
Quantity	Percent of refugees receiving health screening within 90 days of arrival	96%	96%	Sept.2012 Sept 2013
Result	Job retention rate within 90 days	69%	82%	Sept.2012 Sept 2013
Quantity	Average hourly wage	$9.21	$9.15	Sept.2012 Sept 2013

Performance Measure Note: The average hourly wage is the average wage over the previous year for all participants.

The legal authority for the Refugee Services Grants activities comes from federal law: 45 CFR 400

Program: Grant Programs
Activity: Northstar Care for Children

http://www.dhs.state.mn.us/main/id_000150

AT A GLANCE

- 11,510 children experienced an out-of-home placement in 2013
- 1,076 children were either adopted or had a permanent transfer of legal custody to a relative in 2013
- All funds spending for the North Star Care for Children activity for FY 2013 was $67.5 million. This represented 0.6% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Northstar Care for Children is a new program that takes effect January 2015. It is designed to help children who are removed from their homes and supports permanency through adoption or transfer of custody to a relative if the child cannot be safely reunified with parents. Northstar Care for Children consolidates and simplifies administration of three programs: Family FosterCare, Kinship Assistance (which replaces Relative Custody Assistance) and Adoption Assistance. Northstar Care for Children will help more children grow up in safe and permanent homes.

SERVICES PROVIDED

The comprehensive, simplified Northstar Care for Children program:

- Combines three child welfare programs — Family Foster Care, Adoption Assistance and Kinship Assistance — into a single program with uniform processes and unified benefits
- Provides a monthly basic benefit based on children's age
- Uses a uniform assessment for all children to determine any needs beyond the basic payment for one of 15 levels of monthly supplemental difficulty of care payments
- Maintains the highest range of the current foster care benefits for children with the highest need
- Grandfathers children in existing programs under their current programs unless specifically transitioned into Northstar Care for Children (the current programs are slowly phased out as children exit them)
- Reduces barriers to permanency by eliminating disparities in benefits across the existing programs
- Reduces racial disparities among the children who remain in long-term foster care

Funding for Northstar Care for Children comes from state general fund appropriations, federal payments for foster care and adoption assistance, and county or tribal spending on foster care.

RESULTS

The Department of Human Services (DHS) monitors the performance of counties and tribes in delivering child welfare services, and will continue to do so under Northstar Care for Children. DHS expects to see better outcomes for children under Northstar Care.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	Rate of Relative Care: Percentage of children who are in relative family foster homes or pre-adoptive homes compared to children in all family foster care or pre-adoptive homes	30.2%	39.6%	2010 to 2013
Quality	Placement Stability: Percentage of children who have two or fewer placement settings when they are in foster care for less than 12 months	86.8%	85.8%	2010 to 2013
Quality	Timeliness to Adoption: Percentage of children who achieve adoption within 24 months from their most recent entry into foster care	48.2%	54.7%	2010 to 2013

Performance Measures notes:
All measures are from Minnesota's Child Welfare Reports, 2010-2013. Child Protection statistical reports are posted on the DHS Child Protection Publications page (http://www.dhs.state.mn.us/main/id_003712).

Northstar Care for Children is established in M.S. section 256N.20 (https://www.revisor.mn.gov/statutes/?id=256N.20).

Program: Grants Program
Activity: Health Care Grants

AT A GLANCE

- There are currently 990 navigators and in person assisters available state-wide to aid people in obtaining health care coverage.
- 85 of Minnesota's 87 counties collect and track Child and Teen Check-up immunization data.
- All funds spending for the Health Care Grants activity for FY 2013 was $54.1 million. This represents 0.4% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Health Care Grants activity funding provides supports, infrastructure investments or outreach. These grants benefit enrollees in Minnesota Health Care Programs (Medical Assistance (MA) and MinnesotaCare) and some uninsured or underinsured individuals. These grants have historically targeted projects or work that supplements the direct health care services funded under the MA or MinnesotaCare programs.

Some grants in this budget activity augment the agency's own operational efforts. In doing so, we engage experts outside of the Department of Human Services (DHS) to help ensure that eligible Minnesotans are enrolled in the appropriate health care program, and that those enrolled, especially our youngest and/or most vulnerable or hard to reach, receive the needed health care they are eligible for.

SERVICES PROVIDED

The particular set of active health care grants in this budget activity administered by DHS can change over time depending on the length of the funding or project. Health care grants may be for one year or may be ongoing. Grantees can range from providers, counties, or community organizations.

Funding is generally dedicated to a specific project, demonstration or function as directed by legislation. The grants currently funded under this budget activity include:

- *In Person Assister and Minnesota Community Application Agent (MNCAA) Programs*. These funds provide incentive payments to entities assisting people applying to and enrolling in MinnesotaCare and Medical Assistance. These funds provide critical support to people confronted with new eligibility rules and with navigating the new MNsure system.
- *Emergency Medical Assistance Referral and Assistance Grants*: These grants fund organizations to provide immigration legal assistance to people with emergency medical conditions whose immigration status makes them ineligible for Medical Assistance or MinnesotaCare.
- *Child and Teen Checkups and Immunization Registry Grants*. Provides administrative funds for counties to support Immunization registries and MA Child and Teen Checkup services.
- *Adult Medicaid Quality Grants*. Provides funding for grantees to implement quality improvement programs through clinics serving Medical Assistance clients.
- *Diabetes Prevention Program Grants*. Funds incentives for Minnesota Health Care Program recipients participating in the diabetes prevention program, a multi-year evidence-based program supported by the Centers for Disease Control and Prevention.

Health Care Grants are funded with appropriations from the state general fund, health care access fund and with federal funds.

RESULTS

The Health Care Grants activity contributes to the statewide goal of reducing the percentage of Minnesotans that do not have health insurance. DHS collects information on the number of successful applications completed by application agents under the MNCAA and In Person Assister programs.

The *Emergency Medical Assistance Referral and Assistance Grants* activities are ongoing. We are collecting data to track the number of people whose immigration status was a barrier to MA or MinnesotaCare eligibility, but who successfully enrolled after they received immigration legal assistance.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Enrollees receiving support from MNCAAs/In Person Assisters[1]	4,862	16,917	04/2013-09/2013 to 10/2013-03/2014
Quantity	Number of MA recipients receiving disease management services through the Minnesota Diabetes Prevention Program (MN MIPCD)[2]	20	565	03/2013 to 06/2014
Quantity	Number of clinics participating as partners in the Minnesota Diabetes Prevention Program (MN MMIPCD)[3]	3	13	03/2013 to 06/2014

Performance Measure Notes:

1. Measure is the number of Minnesota Health Care Program enrollees receiving application assistance from MNCAAs and In Person Assisters as reported by DHS staff.
2. Measure is the number of MA recipients currently receiving incentives for participating in disease management for pre-diabetes as reported by DHS staff in March 2013 and June 2014.
3. Measure is the number of clinics offering the curriculum and providing disease management services to MA recipients through the Minnesota Diabetes Prevention Program as reported by DHS staff in March 2013 and June 2014.

Minnesota Statutes section 256.962 (https://www.revisor.mn.gov/statutes/?id=256.962) provides the authority to provide incentives for application assistance under the MNCAA program.
Minnesota Statutes section 256B.021 (https://www.revisor.mn.gov/statutes/?id=256.962) provides authority for grants related to reforms in the Medical Assistance program.
Minnesota Statutes section 62V.05 (https://www.revisor.mn.gov/statutes/?id=62V.05) provides authority for the In Person Assister program.

Program: Grant Programs
Activity: Aging & Adult Services Grants

http://www.dhs.state.mn.us/main/id_005734

AT A GLANCE

- Provides congregate dining to 47,000 people, home delivered meals to 13,000 people, and grocery delivery services to 600 people annually.
- Supports more than 20,000 older volunteers per year who provide services through the Retired and Senior Volunteer Program (RSVP), Foster Grandparents, and Senior Companions.
- Provides comprehensive assistance and individualized help to more than 87,000 individuals through 175,000 calls in 2013 through the Senior LinkAge Line®.
- Provides information and community-based resources to 443,000 visitors in 2013 through www.MinnesotaHelp.info (http://www.minnesotahelp.info/), a web-based database of over 36,000 services.
- Provides a long-term options counseling service called Return to Community that helps consumers remain in their homes after a discharge from a nursing facility. From 2010 through 2013, over 5,800 consumers have been contacted for discharge support.
- Funds home and community-based service options for more than 11,000 people and increased capacity by 8,700 volunteers through the Community Service/Services Development grant program.
- All funds spending for the Aging & Adult Services Grants activity was $34.0 million. This represented 0.3% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The purpose of Aging and Adult Services Grants is to provide non-medical social services and supports for older Minnesotans and their families to allow older adults to stay in their own homes and avoid institutionalization.

These funds increase the number and kind of service options for older Minnesotans in both urban and rural communities. This gives greater opportunity for Minnesotans to age at home. Several of the state grant programs are organized with the services provided under the federal Older Americans Act (OAA). Federal OAA funds in Minnesota are administered through the Minnesota Board on Aging. These funds provide core social services to at-risk older adults and their family caregivers who are not yet eligible for public programs. Services are targeted to people with the greatest social and economic need.

SERVICES PROVIDED

Aging and Adult Services Grants promote affordable services that are both dependable and sustainable. These grants are often used along with local private money, including donations. Aging and Adult Services grants provide:

- Nutritional services including congregate meals, home-delivered meals, and grocery delivery.
- Increase the number and kind of service options for older Minnesotans through service development activities funded by the Community Service/Community Services Development (CS/SD), Family Caregiver Support, and ElderCare Development Partnership (EDP) grant programs. Those services include: transportation, help with chores, help with activities of daily living, evidence-based health promotion, chronic disease management, falls prevention services, respite and other supportive services to family caregivers, and other services that help people stay in their own homes.
- Support to older volunteers who provide services through the Retired and Senior Volunteer Program, Foster Grandparent, and Senior Companion programs.
- Comprehensive and individualized help through the Senior LinkAge Line®. The Senior LinkAge Line® trains long-term care options counselors that assist individuals to find community resources and financing options for beneficiaries of all ages.
- Information about community-based resources and customized long-term care planning tools through www.minnesotahelp.info, (http://www.minnesotahelp.info/) a web-based database of over 36,000 services.
- Long-term care options counseling services provided by the Senior LinkAge Line®, known as Return to Community, that help people successfully remain in their homes after discharge from a nursing home. Since the launch of this service in 2010 and

through 2013, over 5,800 consumers have been contacted for discharge support. Of those 5,800, direct assistance was provided to 1,054 older adults at their request to return home and 995 are receiving five years of follow up at home.
- A home and community-based services report card which will provide information to consumers on long-term services and support providers. The report card will be available July 1, 2015. This funding is part of the Reform 2020 initiative approved in November, 2013.
- Core Service grants to nonprofit home and community based service providers who provide in-home and community-based services to older adults. These grants expand the number of organizations that can be supported, which increases the number of individuals served. This funding is part of the Reform 2020 initiative approved in November, 2013.

The Agency administers these grants in partnership with regional Area Agencies on Aging, counties, tribes, and community providers.

Aging and Adult Services Grants support the following strategies in the DHS Framework for the Future: 2014 (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6464C-ENG):

- Keep more people fed and healthy by increasing nutrition assistance participation for seniors
- Serve more people in their own homes, communities, and integrated workplaces.

RESULTS

Minnesota has seen improvement in the number of seniors served by community-based rather than institution-based services. The percent of seniors served in the community has remained steady or improved over the past five years. Through our partners, we surveyed users of the Senior LinkAge Line® and found a consistent proportion of people would recommend Senior LinkAge Line® services to others.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	1. Percent of seniors served by home and community-based services	59.3%	68.4%	2008 to 2013
Quality	2. Percent of consumers who would recommend the Senior LinkAge Line® to others	93%	93%	2007 to 2013
Quantity	3. Number of people who have moved from nursing homes back to the community through the Return to Community Initiative to date	286	1,054	Q2 2010 to Q4 2013
Result	4. Percent of family caregivers who report that the caregiver support services helped them provide care for a longer period of time	93%	95%	2009 to 2013

Results Notes:
1. Measure 1 compares FY2008 to FY2013. This measure shows the percentage of elderly receiving publicly-funded long-term care services who receive HCBS services through the Elderly Waiver, Alternative Care, or home care programs instead of nursing home services. (Source: February 2014 Forecast)
2. Measure 2 compares 2007 data to 2013 data (Source: Consumer Surveys, WebReferral database)
3. Measure 3 compares cumulative quarter 2 CY2010 data to quarter 4 CY2013 data (Source: Return to Community Database)
4. Measure 4 compares CY 2009 to CY 2013 data, as measured by an annual survey of family caregivers receiving Older Americans Act-funded caregiver support services. (Source: Minnesota Board on Aging Caregiver Outcomes Survey)

M.S. sections 256B.0917 (https://www.revisor.mn.gov/statutes/?id=256B.0917) and 256B.0922 (https://www.revisor.mn.gov/statutes/?id=256B.0922) provide the legal authority for Aging and Adult Services Grants. M.S. section 256.975 (https://www.revisor.mn.gov/statutes/?id=256.975) created the Minnesota Board on Aging.

Program: Grant Programs
Activity: Deaf & Hard of Hearing Grants

http://www.dhs.state.mn.us/main/dhs16_139339

AT A GLANCE

- Deaf and Hard of Hearing Grants supported 968 people in state fiscal year 2013. An unknown additional number benefitted from grant funded real-time captioning services.
- 22% of participants in FY13 deafblind programs used the consumer-directed services option.
- Certified Peer Support Specialists became available in FY14 for people who are deaf with serious mental illness.
- This coming year, the interpreting services grants will pilot the delivery of sign language interpreting services through interactive video in Greater Minnesota.
- All funds spending for the Deaf and Hard of Hearing Grants activity for FY 2013 was $2.0 million. This represented 0.02% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Three out of every 1,000 newborns have hearing loss. One-third of people between ages 65-74 have hearing loss and nearly half of those over age 75 have hearing loss.

In Minnesota, an estimated 530,000 to 640,000 people have some degree of hearing loss. Of those, about 11% are deaf and as many as 1,600 individuals are deafblind.

Deaf and Hard of Hearing Services grants help Minnesotans of all ages who are deaf, deafblind and hard of hearing with services and supports they need to live independently and be involved in their families and communities.

The Deaf and Hard of Hearing Services (DHHS) Division administers these grants.

SERVICES PROVIDED

Deaf and Hard of Hearing Grant programs include:

- Sign language interpreter referral and interpreter-related services that allow Minnesotans who are deaf, hard of hearing, and deafblind to access every day activities and core services such as courts, medical care, mental health services, and law enforcement.
- Deafblind grants to support adults who are both deaf and blind so they can live independently and stay in their own homes. Supports include service providers fluent in American Sign Language and trained in specialized communication methods and assistive technology.
- Services for children who are deafblind to provide experiential learning and language development.
- Specialized mental health services provide linguistically and culturally appropriate services including home-based outreach, inpatient therapy, outpatient therapy, family counseling, and educational opportunities for families, schools, and mental health providers.
- Certified Peer Support Specialists for individuals who are deaf and have a serious mental illness.
- Mentors who work with families that have children with hearing loss to develop the family's communication competence, including the use of American Sign Language.
- Real-time television captioning grants to allow consumers in greater Minnesota who are deaf, deafblind, hard of hearing or late deafened to have access to live local news programming from some television stations.

We partner with statewide community providers, mental health professionals, local television stations and the Department of Commerce to provide services.

Deaf and Hard of Hearing grants are primarily funded by the state general fund. In addition, the Telecommunications Access Minnesota (TAM) funds collected by the Department of Commerce funds grants for real-time television captioning of local news programs.

Deaf and Hard of Hearing Grants support the following strategies in the DHS Framework for the Future: 2014 (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6464C-ENG):

- Serve more people in their own homes, communities, and integrated workplaces.

RESULTS

People served in deaf and hard of hearing grant-funded programs fill out surveys to measure satisfaction with the quality and timeliness of services. Over the last two years, they have reported a nearly steady level of satisfaction with services. In Deaf and Hard of Hearing grant-funded mental health programs, the percent of clients who have completed or are making good progress on their treatment goals is increasing. Families with children who are deafblind report noticeable improvement in their child's progress in communication, social development and community integration as a result of the services they receive.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	1. Percent of consumers in DHHS grant-funded programs who are satisfied with quality of services they received	94%	94%	2012 to 2014
Quality	2. Percent of consumers in DHHS grant-funded programs who are satisfied with timeliness of the services they received	89%	86%	2012 to 2014
Quality	3. Percent of clients in DHHS grant-funded mental health programs who completed or are making good progress on their treatment plan goals	89%	97%	2012 to 2014
Quality	4. Percent of parents in DHHS grant-funded programs who observed progress in the communication ability, community integration and social development of their child who is deafblind.	81%	83%	2012 to 2014

Performance Notes:

- Data source: Consumer satisfaction surveys and grantee reports.
- More information on measures one and two is available on the Continuing Care Performance Report (http://www.dhs.state.mn.us/main/dhs16_166609).

M.S. sections 256.01, subd. 2 (https://www.revisor.mn.gov/statutes/?id=256.01), 256C.233 (https://www.revisor.mn.gov/statutes/?id=256C.233), 256C.25 (https://www.revisor.mn.gov/statutes/?id=256C.25), and 256C.261 (https://www.revisor.mn.gov/statutes/?id=256C.261) provide the legal authority for Deaf and Hard of Hearing grants.

Program: Grant Programs
Activity: Disabilities Grants

http://mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/a-z/index.jsp

AT A GLANCE

- The Family Support Grant served 1,810 families in 2008.
- The Consumer Support Grant supported an average of 1,771 people per month in FY2013.
- Semi-independent living services served 1,560 people in 2008.
- HIV/AIDS programs help 2,410 people living with HIV/AIDS.
- The Disability Linkage Line served 23,481 people in FY2013, had 47,887 contacts with consumers, and participated in 63 educational events.
- All funds spending for the Disabilities Grants activity for FY 2013 was $41.8 million. This represented 0.3% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The US Census Bureau estimates that nearly 400,000 or 14 percent of Minnesotans have a disability or disabling condition.

Disabilities Grants provide services and supports to help Minnesotans with disabilities remain in their communities and avoid institutionalization. This work is done by counties, tribes, families and local providers.

These funds increase the number and kinds of service options for people with disabilities and their families; help people with HIV/AIDS with medical expenses; provide information and assistance on disability programs and services; and support county and tribal service infrastructure.

More information about Disabilities Grants and the number of people served is available in a Disabilities Grants fact sheet.

SERVICES PROVIDED

Disabilities Grant programs include:

- The Family Support Grant (FSG) which provide cash to families to offset the higher-than-average cost of raising a child with a disability.
- The Consumer Support Grant (CSG) which helps people purchase home care, adaptive aids, home modifications, respite care, and other help with the tasks of daily living.
- Semi-Independent Living Services (SILS) grants which help adults with developmental disabilities to live in the community. The funding is used to purchase instruction or assistance with nutrition education, meal planning and preparation, shopping, first aid, money management, personal care and hygiene, self-administration of medications, use of emergency resources, social skill development, home maintenance and upkeep, and use of transportation.
- HIV/AIDS programs which help enrollees pay premiums to maintain private insurance, co-payments for HIV-related medications, mental health services, dental services, nutritional supplements, and case management.
- Housing Access Services grants which support a non-profit organization to help individuals move out of licensed settings or family homes and into their own homes.
- The Disability Linkage Line (DLL) which provides one-to-one assistance to help people learn about their service options and connect them with the supports and services they choose.
- Local planning grants to assist counties and tribes in development of community alternatives to corporate foster care settings. During FY 2015, this funding will be used by selected counties to implement specific plans to address the needs of people with disabilities in their communities.
- The Advocating Change Together grant which provides funding to a statewide self-advocacy organization for people with disabilities.
- Technology Grants for Corporate Foster Care Alternatives which funds a non-profit organization to provide person-centered assistive technology and case consultation to individuals with disabilities, their case manager, and others chosen by the individual. Consultations include assistive technology evaluations and technical assistance, information, and training for individuals with disabilities living in their own home or seeking to live in their own home.
- A grant to People, Inc. to provide a living skills training program for people with intractable epilepsy who need assistance in the transition to independent living.

- Transition Initiatives to Waivered Services for Certain Populations grants provide help pay for specialized services that are sometimes needed by individuals transitioning back to the community from state institutions, once the person has met their treatment goals and no longer require the level of treatment and supervision provided at these facilities.
- Day Training and Habilitation (DT&H) grants which are allocated counties. These grants help counties purchase services that help people living in an Intermediate Care Facility for persons with Developmental Disabilities to develop and maintain life skills and participate in community activities.
- An annual grant to Region 10 to assist with developing the State Quality and Licensing system.
- Several new grants that will be implemented starting in FY 2015: Work Empower grants, Autism grants, and grants to Housing Opportunities for Persons with AIDS.

The Disabilities Grants activity is funded by the state's general fund, federal funds and special revenue funds. The HIV/AIDS programs receive federal funds from the Ryan White Care Act and also rebate funding from pharmaceutical companies for drugs and insurance.

These grants support the following strategies in the DHS Framework for the Future: 2014 (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6464C-ENG):

- Serve more people in their own homes, communities, and integrated workplaces.

RESULTS

The agency monitors data, reviews counties, and administers surveys to consumers to evaluate services. Minnesota has seen continuous improvement in the number of people with disabilities served by community-based rather than institution-based services.

A 2009 moratorium in state law on corporate foster care helped to curb the growth of residential settings. The agency tracks the percent of people with disabilities who receive home and community-based services in their own home instead of in a congregate residential setting, such as foster care.

More information is also available on the DHS dashboard (http://dashboard.dhs.state.mn.us/) and the Continuing Care Performance Report (http://www.dhs.state.mn.us/main/dhs16_166609).

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	1. Percent of people with disabilities who receive home and community-based services in their own home.	71.4%	73.5%	2008 to 2013
Quantity	2. Number of people that Housing Access Services has helped move to a home of their own each year.	14	297	2009 to 2013
Quality	3. Percent of consumers who would recommend the Disability Linkage Line (DLL) to others.	99%	99%	2008 to 2013

Performance Measures Notes:

1. Measure is people who are age 19 to 64. Compares FY 2008 (Previous) to FY2013 data (Current). Source: February 2014 Forecast.
2. Compares calendar year 2009 (Previous) to CY 2013 (Current). Since the program began, Housing Access Services has moved over 1,000 people with disabilities into homes of their own. Source: DHS Grant reports.
3. Compares CY 2008 data (Previous) to CY 2013 data (Current). Source: DLL Customer Satisfaction Surveys.

M.S. sections 252.275 (https://www.revisor.mn.gov/statutes/?id=252.275); 252.32 (https://www.revisor.mn.gov/statutes/?id=252.32); 256.01, subds. 19, 20, and 24 (https://www.revisor.mn.gov/statutes/?id=256.01); 256.476 (https://www.revisor.mn.gov/statutes/?id=256.476); and 256B.0658 (https://www.revisor.mn.gov/statutes/?id=256b.0658) provide the legal authority for Disabilities Grants.

Program: Grant Programs
Activity: Adult Mental Health Grants

http://mn.gov/dhs/people-we-serve/adults/health-care/mental-health/index.jsp

AT A GLANCE

- Approximately 223,798 adults in Minnesota have a serious mental illness.
- Provided mental health services through MHCP to 124,587 in CY 2013.
- Provided PATH homeless outreach service to 3,934 persons and enrolled 1,937 in PATH services in CY 2013.
  - At the time of enrollment 1,195 were literally homeless and 742 were at imminent risk of homelessness.
- Provided Crisis Housing Assistance in CY 2013 to prevent homelessness for 244 persons seeking facility based treatment.
- 2,127 received Residential Treatment (IRTS) in CY 2013.
- 1,991 received Assertive Community Treatment in CY 2013.
- Provided Crisis Services in response to 10,918 crisis episodes in FY 2013.
- 17,589 received mental health case management services through MHCP in CY 2013.

PURPOSE & CONTEXT

The Adult Mental Health Division, a division of the Chemical and Mental Health Services Administration, receives both federal and state funding to support services for adults with mental illness. These funds, combined with county dollars, are used to identify and meet the local service need by developing and providing a range of mental health services in the community. Adult Mental Health Grants support the mission of the Minnesota Comprehensive Adult Mental Health Act by supporting community mental health system infrastructure and services. The grants are used in conjunction with healthcare coverage and other funding sources to support individuals in independent living and community service and treatment options. Services are delivered using best practice and evidence-based practice models that are person-centered and effective

SERVICES PROVIDED

Adult Mental Health Grants support a broad range of vital community service needs. The grants provide funding for infrastructure, community services, supports, and coordination activities not covered by federal Medicaid reimbursement, and/or for persons who are uninsured or under-insured by public or private health plans. Services include, but are not limited to the following:

Community Support Program and Adult Mental Health Initiative Grants

- Targeted Case Management
  Activities that coordinate other support services to help adults with serious and persistent mental illness gain access to needed medical, social, educational, vocational services. These activities include developing a functional assessment, an individual community support plan, and ensuing coordination of services and monitoring of service delivery. Grants support increased case management service capacity.

- Assertive Community Treatment (ACT)
  Intensive non-residential mental health services are provided by a multidisciplinary staff using a team model. The team includes at a minimum, a psychiatrist, mental health professional, registered nurse, vocational and substance abuse specialists. ACT services are available 24 hours a day. ACT teams assume full responsibility for the individual's mental health treatment. This service continues to save dollars by keeping people in the community and preventing hospitalization. Current ACT teams address the need for integrated care.

- Adult Rehabilitative Mental Health Services (ARMHS)
  ARMHS Services are services that enable a recipient to develop, retain and enhance their mental stability and functioning by providing education on medication management, basic social and living skills, household management, employment-related, or transitioning to community living.

- Adult Outpatient Medication Management
  Provides for prescriptions, medication education, and reviews to help individuals manage their symptoms.

- Basic Living /Social Skills and Community Intervention
  Basic living /social skills and community intervention services provided to help individuals live safely and inclusively in the community.

Housing

- Project for Assistance in Transition from Homelessness (PATH)
  PATH is a Federal program with a State match to provide homeless outreach, service coordination, and related services designed to find and engage persons with serious mental illness who are homeless or at imminent risk of becoming homeless in services, basic needs, resources, and housing.

- Crisis Housing
  Direct payments for rent, mortgage, and utility costs, to assist persons with retaining their housing while getting needed facility based treatment. The program prevents homelessness while the individual uses their income to pay for treatment or losses income while getting needed treatment.

- Housing with Supports
  These grants fund the development of permanent supportive housing for persons with serious mental illness, by providing options that assist individuals who need housing with linked supports to help maintain an individual's mental health and housing stability while living in the community.

Crisis Response Services

An array of services from mobile crisis response teams to crisis stabilization beds and aftercare services. Mobile crisis teams respond to an individual's call for help in their home, place of employment, or possibly to an emergency department in a hospital. Many components of crisis services are not reimbursable under Medicaid, such as telephone contacts with a person in crisis, linkage and coordination, benefits assistance, and post-hospital transition services. These services are being provided through grant funding.

Workforce Development

- Culturally specific grants
  Grants expand capacity for ethnically and culturally-specific, trauma-informed, adult mental health services within target cultural and ethnic minority communities in Minnesota. These grants support the collaboration between professional schools and mental health agencies in administratively supporting the efforts of cultural and ethnic minority students and graduates of mental health professional training programs seeking to obtain licensure.

- Individual Placement Supports (IPS) - Supported Employment
  Counties use adult mental health grants to fund evidence-based practices such as the IPS model of supported employment to improve the ability of adults with serious and persistent mental illness to find and maintain competitive employment. Grants support necessary staffing and infrastructure-building for IPS such as training, implementation supports, quality monitoring of IPS services and long-term, time-unlimited follow-up supports directed to mental health service providers.

- Minnesota Center for Chemical and Mental Health (MNCAMH)
  These grants fund training and technical assistance from the Minnesota Center for Chemical and Mental Health (MNCAMH), a program of the University of Minnesota drawing from the strengths of the School of Social Work, the College of Continuing Education, and the Department of Psychiatry. MNCAMH is a center of excellence for workforce training created to advance the professional development of the treatment services workforce on research informed practices for recovery-oriented systems of care.

- Certified Peer Specialist (CPS) Implementation and Training
  Selected and qualified individuals with a lived experience of mental illness are trained to work as Certified Peer Specialists in Assertive Community Treatment (ACT), Adult Rehabilitative Mental Health Services (ARMHS), Crisis Response Services and Intensive Residential Treatment services. As of July 31, 2014, two hundred and ninety four (294) individuals including forty three (43) veterans have been trained and certified as Certified Peer Specialists.

RESULTS

Crisis Response Services Results

Adult residents in every county in the state can access some form of Crisis Response Services.

- In FY2013 Mental Health Crisis Services responded to 10,918 crisis episodes.
- Crisis response services provide support and interventions that allow people to remain in the community and avoid additional life disruption that a hospital stay entails. In CY2013 only 15% of people who received a crisis service needed hospitalization after intervention.

Assertive Community Treatment Results

ACT services continue to demonstrate consistent results in improving mental wellness for the individuals treated by an ACT team. Most recently, ACT teams have focused on improving the physical health of individuals with mental illness through better linkages with primary care clinics. The following table provides information on the improvements in the number of individuals served by ACT teams who are receiving an annual physical exam. These performance measures indicate the positive trends for individuals with mental illness served by ACT teams. With ongoing training and focus on these areas, this trend is expected to continue to improve.

Housing with Supports Results

Since implementation the Housing with Supports for Adults with serious mental illness has supported 1,128 units across 53 projects. By the end of CY 2012, the program was actively supporting 648 units across 35 current or developing projects at an average cost per unit per year of $3,540.

Additional Results – ACT and ARMHS

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	Percent of Adults in Assertive Community Treatment (ACT) who have received an annual comprehensive preventative exam.[1]	72%	82%	2012 - 2013
Result	Percent of Adults with serious mental illness who remain in the community six months after discharge from an inpatient psychiatric setting.[2]	75%	75%	2011 - 2012
Result	Reduction in inpatient days for persons served in Assertive Community Treatment (ACT)[3]	54%	54%	FY 2011- FY 2012
Quantity	Number of Adults with Serious Mental Illness who received Adult Rehabilitative Mental Health Services (ARMHS). [4]	14,883	17,452	2011 - 2013

Measure Notes:

1. Compares Dec 2012 (Previous) and Dec 2013 (Current). The measure is based on ACT teams reporting on clients who had annual physical exams within the last year of those whose last annual physical date was known. (DHS Public Dashboard)
2. Previous measures Calendar Year 2011 and Current measures CY 2012. The measure looks at a readmission to any psychiatric inpatient care unit (either State Operated or Community) within six months of discharge from a psychiatric inpatient care unit.
3. Previous measure is the percent reduction in mental health inpatient days for ACT clients admitted in FY 2010. Current measure is the percent reduction in mental health inpatient days for ACT clients admitted in FY 2012. The percent reduction compares the year before starting program with the year after starting the program. The department goal is to reduce the need for hospitalization and keep persons served in the community.
4. Previous measures Calendar Year 2011 and Current measures Calendar Year 2013 number of individuals receiving adult rehabilitative mental health services (ARMHS).

Minnesota Statutes, sections
245.461 – 245.90 (https://www.revisor.mn.gov/statutes/?id=245)
254 (https://www.revisor.mn.gov/statutes/?id=254)
254A (https://www.revisor.mn.gov/statutes/?id=254A)
254B (https://www.revisor.mn.gov/statutes/?id=254B)
256 (https://www.revisor.mn.gov/statutes/?id=256) provides the legal authority for these services.

Program: Grant Programs
Activity: Child Mental Health Grants

http://www.dhs.state.mn.us/main/id_000162

AT A GLANCE

- 9% of school-age children and 5% of preschool children in Minnesota have a mental health problem that has become longer lasting and interferes significantly with the child's functioning at home and in school
- An estimated 109,000 children and youth in Minnesota (from birth to age 21) need treatment for serious emotional disturbance
- Each year about 70,100 children and youth receive publicly funded mental health services in Minnesota
- Approximately 27,500 children and youth received mental health screenings through Medical Assistance Child and Teen Checkup services, as well as in the child welfare and juvenile corrections systems in 2013
- All funds spending for the Child Mental Health Grants activity for FY 2013 was $17.4 million. This represented 0.1% of the Department of Human Services overall budget

PURPOSE & CONTEXT

The Children's Mental Health Division, a division of the Chemical and Mental Health Services Administration, receives both federal and state funding to support services for children with mental illness. These grants fund community, school, and home-based clinic-based children's mental health services provided by non-profit agencies, schools, Medicaid-enrolled mental health clinics, tribes, counties, and culturally specific agencies. Grants pay for treatment services for children who are uninsured or whose family insurance does not cover the necessary mental health services. In addition, grants fund the coordination of mental health services with physical healthcare and services for persons with developmental disabilities. These grants also help to build alternatives to inpatient hospitalization and residential treatment.

SERVICES PROVIDED

Children's Mental Health Grants promote integration of mental health services into the state's overall healthcare system by:

- filling gaps in the services continuum until needed services and supports can be established in the broader Minnesota Health Care Programs benefits set;
- paying for necessary ancillary services, supports, and coordination activities that are not yet eligible for federal Medicaid reimbursement;
- covering treatment and supports for children who remain uninsured or under-insured by public or private health plans; and
- building statewide service delivery capacity in workforce-shortage areas, where key services are not available regardless of insurance coverage.
- expanding access to direct treatment by providing care in community, school, home, and clinic-based children's mental health settings,
- providing coordination of mental and chemical health services with physical healthcare, services for persons with developmental disabilities, and county social services
- training providers on evidence-based practices, neglected in professional training schools
- funding measurement of treatment outcomes

Partners are essential in order to develop and maintain a dynamic and competent mental health service delivery system. For children, coordination of care must include other child-serving sectors of the public and private health and human service systems of Minnesota—such as:

- primary health care,
- day care,
- substance abuse treatment,
- schools,
- public health,
- child welfare,
- juvenile justice,
- adult transition services, and
- services to parents designed to prevent traumatic events in a child's life and to build or repair the crucial parent-child attachment bond.

The Children's Mental Health Division of the agency's Chemical and Mental Health Services Administration administers this grant activity to support services for children with mental illness.

RESULTS

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Service Utilization Rate (per 10,000 children)[1]	437	493	2010 - 2012
Quantity	Percent of Children in the child welfare system who received a mental health screening	55.3%	56.6%	2010 - 2012

Measure Notes:

- Service Utilization Rate: An indicator of service access, this indicator counts the number of children (under age 18) receiving any mental health service from the publicly financed health care system, per 10,000 children in the general child population. Compares Calendar Year (CY) 2010 (Previous) and CY 2013 (Current). The utilization rate is not an indicator of need for services, because the incidence of emotional disturbance is far higher than the rate at which children access treatment.
- Percent of Children receiving a mental health screening: With parental consent, counties conduct mental health screenings for children in the child welfare and juvenile justice systems who have not had a recent assessment. The previous measure is CY 2010; the current measure is CY 2012

Minnesota Statutes, section 245.4889 (https://www.revisor.mn.gov/statutes/?id=245.4889) provides the legal authority for Children's Mental Health grants.

Program: Grant Programs
Activity: CD Treatment Support Grants

CD Treatment Support Grants (http://www.dhs.state.mn.us/main/id_000082)
Compulsive Gambling (http://www.dhs.state.mn.us/main/id_008538)

AT A GLANCE

- In the United States, 22.2 million persons, age 12 and older are chemically dependent. (CY2012 data)
- 50,801 persons in Minnesota received treatment for chemical dependency in CY2013.
- 53.6% completed chemical dependency treatment.
- Compulsive gambling helpline receives about 1,000 calls each year for information or referrals to treatment.
- All funds spending for the CD Treatment Support Grants activity for FY 2013 was $17.3 million. This represented 0.1% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The CD Treatment Support Grants activity uses both federal and state funding to supporting state-wide prevention, intervention, recovery maintenance, case management and treatment support services for persons with alcohol, or drug addiction. Treatment support services include subsidized housing, transportation, child care, parenting education.

This activity also houses the state Compulsive Gambling Treatment Program.

SERVICES PROVIDED

CD Treatment Support Grants provide:

- Community drug and alcohol abuse prevention, intervention, and case management services for communities of color, the elderly, disabled, individuals with a mental illness and chemical dependency, individuals experiencing chronic homelessness, and people involved in the criminal justice system.
- Treatment supports specifically targeted to women, women with children, the elderly, and other diverse populations.
- A statewide prevention resource center that provides education and capacity building on the misuse of alcohol and other drugs. Education includes delivering information and training to counties, tribes, local communities, and other organizations.
- Community-based Planning and Implementation (prevention) grants that use a public health approach to preventing alcohol use problems among young people.
- Compliance monitoring of tobacco retailers to make sure that retailers do not sell tobacco to youth.

Additional information is in the March 2013 report, *Minnesota's Model of Care for Substance Use Disorder* (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6706-ENG).

Most of the funding for CD Treatment Support Grants comes from the U.S. Dept. of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant. Additional funding comes from the SAMHSA Strategic Prevention Framework State Incentive Grant. State appropriations provide additional funding for drug and alcohol abuse prevention, treatment support and recovery maintenance services for Native Americans.

The state's Compulsive Gambling Program provides:

- public awareness campaigns to promote information and awareness about problem gambling;
- a statewide helpline and educational programming;
- funding for problem gambling assessments, outpatient and residential treatment of problem gambling and gambling addiction;
- training for gambling treatment providers and other behavioral health service providers; and
- research which evaluate awareness, prevention, education, treatment service and recovery supports related to problem gambling and gambling addiction.

Public awareness campaigns target Minnesotans statewide. The Compulsive Gambling statewide helpline (http://www.getgamblinghelp.com/about-us/) generally receives about one thousand calls requesting information or referrals for

treatment services each year. The Compulsive Gambling Treatment program provides funding for approximately 700 people per year for outpatient treatment services. An average of approximately 160 people receives residential treatment each year.

The Compulsive Gambling Treatment program is largely funded by a portion of state lottery proceeds, and a dedicated half-percent of the revenue from the state tax on lawful gambling proceeds.

The Alcohol and Drug Abuse Division, a division of the agency's Chemical and Mental Health Services Administration, administers the programs and grants within the CD Treatment Support Grants activity.

RESULTS

Minnesota communities that received Planning and Implementation grants saw a 27% reduction in the measure of past 30-day use of alcohol use by youth between 2004 and 2010. The rest of the state saw a 24% reduction in that measure over the same 2004 and 2010 period. The first row in the table below reports more recent data on this measure in communities that received this prevention funding.

Type of Measure	Name of Measure	Previous	Current	Dates
Result	Past 30 day use of alcohol by youth in communities that are receiving a Planning and Implementation grant for prevention funding. (Numbers in parenthesis are statewide numbers for comparison)	24.5% (19.2%)	17.9% (14.5%)	2010 vs. 2013
Result	Babies born with negative toxicology results	88%	81%	2011 vs. 2012

Measure Notes:

- The Past 30 day use of alcohol measure consists of data as reported in the Minnesota Student Survey (http://www.health.state.mn.us/divs/chs/mss/) for 9th grade students who self-report on their use of alcohol in the last 30 days. Previous represents calendar year CY 2010 and Current represents CY 2013.
- The Babies born with negative toxicology measure is the percentage of babies with negative toxicology results during a 12-month period, born to women served by the state Women's Recovery grants. Previous represents FY 2011 and Current represents FY 2012.

Minnesota Statutes, chapters 254A (https://www.revisor.mn.gov/statutes/?id=254A), 254B (https://www.revisor.mn.gov/statutes/?id=254B) and 256, (https://www.revisor.mn.gov/statutes/?id=256) and sections 245.98 (http://www.revisor.mn.gov/statutes/?id=245.98) and 297.E02, subd. 3 (https://www.revisor.mn.gov/statutes/?id=297E.02) provide the legal authority for CD Treatment Support Grants.

Program: State Operated Services (SOS)
Activity: SOS Mental Health

http://mn.gov/dhs/people-we-serve/adults/services/direct-care-treatment/index.jsp

AT A GLANCE

- Mental illness affect one in five families
- The US spends more than $100 billion a year on untreated mental illness
- State Operated Services provided mental health inpatient and residential services to approximately 1,600 people in FY2014
- SOS Community Health Clinics provided 5,260 services in FY2014
- Community Support Services provided services to 723 people during FY2014
- All funds spending for the DCT State Operated Services (SOS) activity for FY 2013 was $125.0 million. This represented 1.0% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

As part of the Department of Human Services Direct Care and Treatment (DCT) Administration, State Operated Services (SOS) Mental Health provides specialized treatment and support services to individuals with mental illness, intellectual disabilities and other complex conditions.

The Department of Human Service's goal is to serve people with mental illness and intellectual disabilities by providing access to care close to their home community and natural supports. SOS provides services to individuals at different levels of the continuum to allow them to move through the system and back to the community.

SERVICES PROVIDED

The following services are funded with general fund appropriations:

- Adult in-patient services at the Anoka Metro Regional Treatment Center (AMRTC)
- Adult in-patient services at the Community Behavioral Health Hospitals (CBHHs) located in Alexandria, Annandale, Baxter, Bemidji, Fergus Falls, Rochester and St. Peter
- Child & Adolescent Behavior Health in-patient Services (CABHS) in Willmar
- Minnesota Specialty Health System – providing Intensive Residential Treatment Services (IRTS) in Brainerd, St. Paul, Wadena and Willmar
- Community Support Services (CSS) – statewide mobile teams providing crisis support services to individuals with disabilities in their home community

Services funded with other revenues:

- Community Health Clinics – provide dental care and medication management to individuals with developmental disabilities. Clinics are located in Brainerd, Cambridge, Faribault, Fergus Falls and Willmar.
- Community Partnership Network – through shared services agreements with the counties, SOS staff work in teams to provide Assertive Community Treatment (ACT) and Adult Rehabilitative Mental Health Services (ARMHS).

All services:

- are person-centered, focusing on the needs of the individual,
- are provided in a safe and appropriate level of care environment and,
- allow individuals to move through treatment and back to the most integrated setting possible.

To assure a successful community transition, we use key strategies such as:

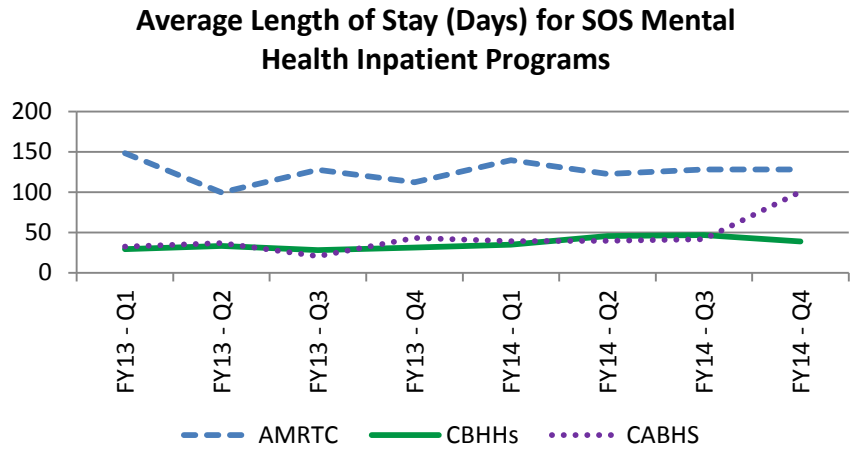
- Prompt psychiatric follow-up upon their return to a community setting and,
- Reducing the number of medications necessary to control the individual's symptoms.

We also reach out to partner with community providers to remove the barriers that limit successful transitions back to the community.

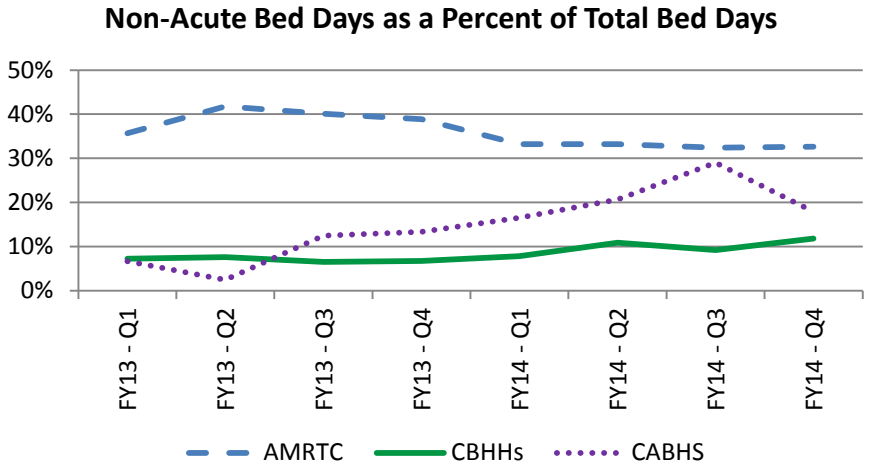
RESULTS

We measure success by the reduction in the length of stay in our inpatient programs. Shorter lengths of stays give clients a greater chance to retain their community support services and living arrangements. The graph below indicates that the average length of stay at AMRTC has steadily increased since early FY2013. The increase in length of stay is related to challenges in finding a community placement when a client is ready to be discharged.

The spike in CABHS in the last quarter is related to one client. The average length of stay for the CBHHs had remained fairly consistent.



Another measure of success is the reduction of non-acute bed days. A non-acute bed day is a day spent in the hospital when the client no longer needs that level of care. When a client does not need hospital level of care but cannot be discharged, it restricts the system flow, is costly and causes other clients who need hospital level of care to remain on the waiting list. Our goal for inpatient services is that only 10% of total bed days are classified as non-acute bed days.



The graph above shows that although the non-acute bed day percentage at AMRTC is declining, it is still too high. The CBHH non-acute bed days percentage has increased slightly but remains close to the 10% goal. The CABHS program operates few beds, so having just one or two clients who do not meet hospital level of care has a great impact on the non-acute bed day measure.

Minnesota Statutes sections 246.01 to 246.70 (https://www.revisor.mn.gov/statutes/?id=246)provide the legal authority for State Operated Services.
Also see Minnesota Statutes section 256.0121 (https://www.revisor.mn.gov/statutes/?id=256.0121)for additional information related to the Southern Cities Community Health Clinic

Program: State Operated Services (SOS)
Activity: SOS Enterprise Services

Activity Website: Direct Care and Treatment (http://mn.gov/dhs/people-we-serve/adults/services/direct-care-treatment/index.jsp)

AT A GLANCE

- 2,043 clients served in the Community Addition Recovery Enterprise (C.A.R.E.) program during FY2014
- 30 children and adolescents with severe emotional disturbance served in individual foster homes during FY2014
- 487 clients with developmental disabilities served in residential services during FY2014
- 925 clients with developmental disabilities served in day treatment and habilitation vocational services during FY2014

PURPOSE & CONTEXT

As part of the Department of Human Services Direct Care and Treatment (DCT) Administration, State Operated Services (SOS) Enterprise Services provides treatment and residential care to individuals with: chemical dependency, behavioral health issues and developmental disabilities. SOS enterprise programs specialized in the treatment of vulnerable people with complex needs for whom no other providers are available.

Enterprise services operate on the revenues generated from services provided to clients. Revenues are collected from third-party payment sources such as Medical Assistance, private insurance, and the clients themselves.

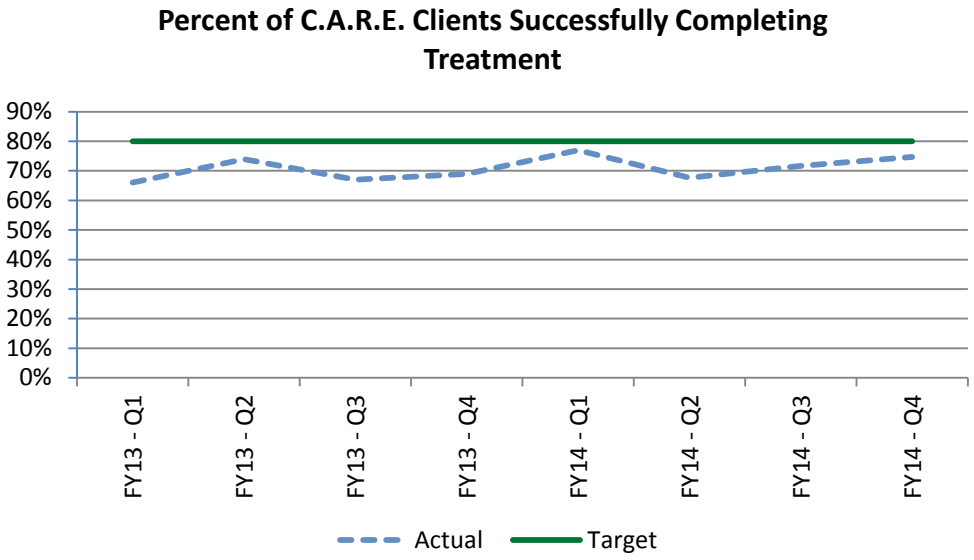
SERVICES PROVIDED

Service programs within this activity include:

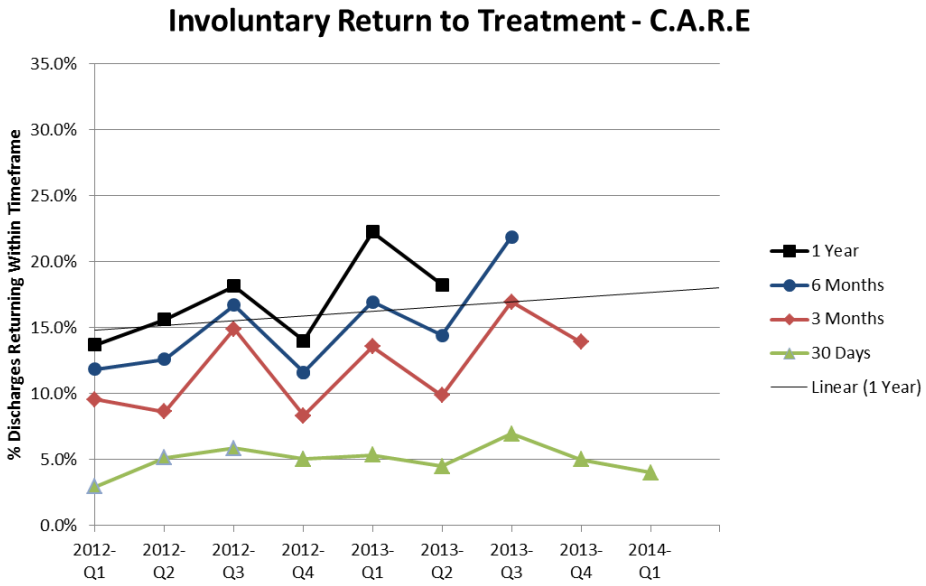
- Community Addiction Recovery Enterprise (C.A.R.E.) – provides inpatient and outpatient treatment to persons with chemical dependency or substance abuse problems. C.A.R.E. programs operate in Anoka, Brainerd, Carlton, Fergus Falls, St. Peter, and Willmar.
- Minnesota Intensive Therapeutic Homes (MITH) – provides foster care to children and adolescents who have severe emotional disturbance and serious acting-out behaviors. Homes are located throughout the state. Each child's treatment structure is individualized and is based on a combination of multidimensional treatment, wrap-around services and specialized behavior therapy.
- Minnesota State Operated Community Services (MSOCS) – provides residential services in small group homes (typically 4 beds) located throughout the state for individuals with developmental disabilities. Staff members assist clients with activities of daily living and help integrate them into the local communities. Individual service agreements are negotiated with counties for each client based on their needs.
- Day Training and Habilitation (DT&H) – provides vocational support services for people with developmental disabilities. Services include evaluation, training and supportive employment. Individual services agreements are negotiated for each client.

RESULTS

We measure success in the C.A.R.E. program by the percent of individuals completing treatment. This is an indication of a client's engagement within the program. Completing treatment increases the likelihood that a client will maintain sobriety after discharge. Our target goal is 80% completion. The below chart indicates we are slightly below this goal.



One test of whether we have truly assisted the people we serve to prepare to live successfully in the community is the rate at which they return to treatment involuntarily. Understanding the reasons why the people we serve return to treatment involuntarily can help us to improve our programs. In this chart, involuntary return to any C.A.R.E. facility is measured at 1 month, 3 months, 6 months, and 1 year intervals from the time of discharge. The 1-year trend has decreased from 2013 predictions, and more recent short-term results show decreased rates of return to treatment as well.



We measure the success of our enterprise Day Training and Habilitation programs by the percent of individuals served by the programs who are employed in their community. This demonstrates our commitment to enabling people with disabilities to do useful work and be productive citizens. Our goal for this measure is 75%.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	The percent of individuals served within DT&Hs who have community employment	56%	71%	July 2013 vs. July 2014

Minnesota Statutes, sections 246.01 to 246.70 (https://www.revisor.mn.gov/statutes/?id=246) provide the legal authority for State Operated Services.

Program: State Operated Services (SOS)
Activity: SOS MN Security Hospital

http://mn.gov/dhs/people-we-serve/adults/services/direct-care-treatment/index.jsp

AT A GLANCE

- Minnesota Security Hospital served 255 individuals during FY2014
- Average length of stay is 6.2 years
- Transition Services served 118 individuals during FY2014
- Competency Restoration Program served 89 individuals during FY2014
- Forensic Nursing Home served 47 individuals during FY2014
- Overall, the Forensic Services census is forecasted to increase by 2-3 individuals per year
- All funds spending for the DCT SOS MN Security Hospital activity for FY 2013 was $71.2 million. This represented 0.6% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

As part of the Department of Human Services Direct Care & Treatment (DCT) Administration, the Minnesota Security Hospital (MSH) in St. Peter is a secure treatment facility that provides multidisciplinary treatment services to adults and adolescents with severe mental illness that have endangered others and present a serious risk to the public.

Clients are admitted as a result of judicial or other lawful orders. Clients come from throughout the state. Most are under a civil commitment as mentally ill and dangerous (MI and D).

The 2014 Legislature appropriated $56 million in bonding to construct new residential and program areas to help create a safer and more therapeutic environment at MSH.

SERVICES PROVIDED

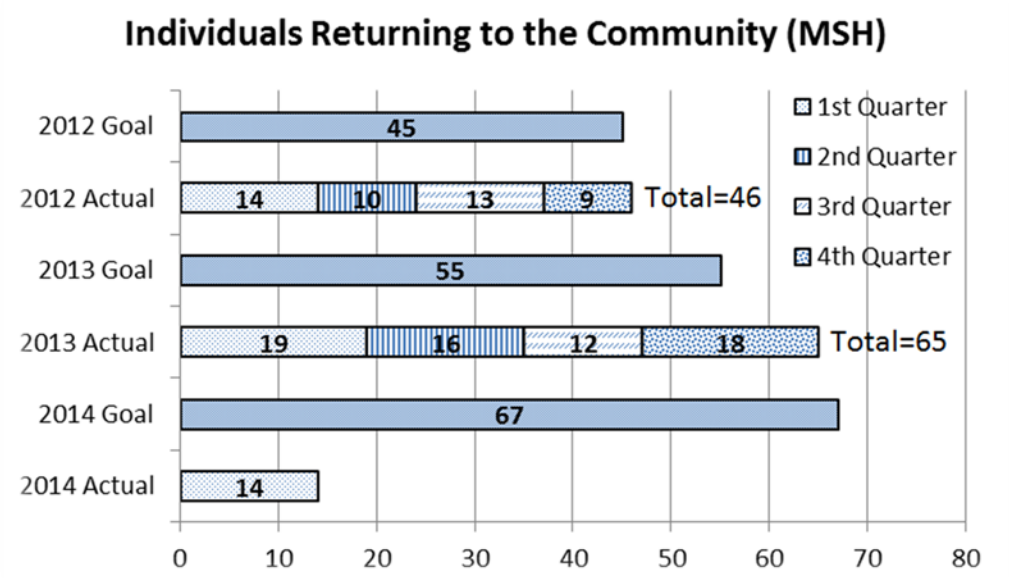
Forensics Services programs provide a continuum of services:

- Minnesota Security Hospital – MSH provides a secure inpatient setting for treatment of severe mental illness for individuals committed as mentally ill and dangerous.
- Competency Restoration Services – provide treatment and evaluation of individuals who have been committed for competency restoration under Minnesota Court Rules of Criminal Procedure Rule 20.01 Subd. 7 (https://www.revisor.mn.gov/court_rules/rule.php?name=cr-20).
- Transition Services - provide a supervised residential setting offering social rehabilitation treatment to increase self-sufficiency and build skills necessary for a safe return to the community.
- Forensic Nursing Home - provides nursing home level of care to individuals committed as mentally ill and dangerous, a sexual psychopathic personality, sexually dangerous person or on medical release from the Department of Corrections.
- Court-ordered evaluations – include evaluations of a person's competency to stand trial and pre-sentencing mental health evaluations. These can be done on either an inpatient basis at the Minnesota Security Hospital or in a community setting, including a community corrections facility.

All of these services are provided through a direct general fund appropriation.

RESULTS

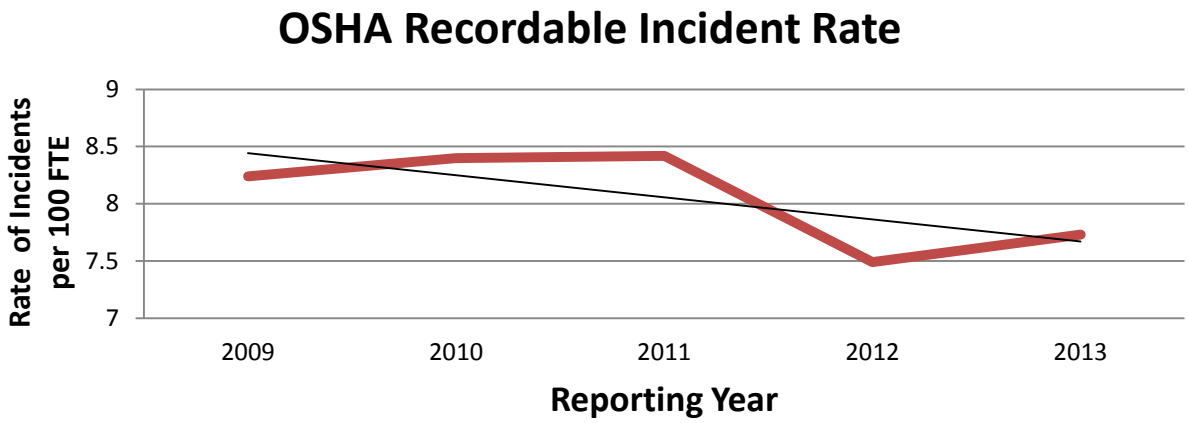
We measure success by the number of individuals provisionally discharged from Forensics Services programs. Our goal for calendar year 2012 was to discharge 45 individuals. The top set of bars in the graph below shows that we discharged 46 individuals. Our goal for calendar year 2014 was to discharge 55 individuals. The middle set of bars in the graph below shows that we discharged 65 individuals. Our goal for calendar year 2014 is to discharge 67 individuals. The bottom set of bars in the graph below shows that 16 individuals were discharged within the first quarter of CY2014, which is on target to meeting our goal.



To prepare for transitioning back to the community, clients participate in therapeutic work activities. These activities build a person's skills and work habits that make the transition to a job placement easier. We report an increase in the percentage of clients participating in work activities in the table below.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Percent of eligible clients who are engaged in therapeutic work activities	61.4%	72.7%	FY 2013 FY 2014

We care about the safety of our clients and staff. One measure of safety is the rate at which employees have injuries or illnesses that are reportable to the federal Occupational Safety Health Administration (OSHA). Many efforts are underway at MSH to lower this rate. In the chart below, the dashed line is baseline annual data. It is imposed on top of an underlying solid trend line. The baseline annual data show a slight upward trend through 2012, although 2013 rates are lower. More data is needed to determine if we are "turning the curve".



Performance Notes:

- The OSHA Recordable Incident Rate is the total number of workplace injuries or illnesses per 100 full time employees (FTE) working in a year that must be reported to the federal Occupational Safety and Health Administration. For 2012, the national average among psychiatric and substance abuse hospitals was 8.4 incidents per 100 FTE.

Minnesota Statutes, sections 246.01 to 246.70 (https://www.revisor.mn.gov/statutes/?id=246) provide the legal authority for State Operated Services. Also see Minnesota Statutes, sections 253.20 to 253.26 (https://www.revisor.mn.gov/statutes/?id=253) for additional authority that is specific to MSH.

Program: Minnesota Sex Offender Program

http://www.dhs.state.mn.us/main/dhs16_149914

AT A GLANCE

- Minnesota Sex Offender Program served 697 clients as of July 1, 2014.
- Clients progress across three phases of treatment through active participation in group therapy and opportunities to demonstrate meaningful change.
- On average in 2013-14, 80 percent of MSOP treatment-eligible clients voluntarily participated in treatment.
- One MSOP client was provisionally discharged in 2012.
- All funds spending for the Minnesota Sex Offender Program activity for FY 2013 was $73.7 million. This represented 0.6% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Minnesota is one of 20 states with civil commitment laws for sex offenders.

As part of the Department of Human Services Direct Care and Treatment (DCT) Administration, the Minnesota Sex Offender Program (MSOP) provides services to individuals who have been civilly committed to receive sex offender treatment. Most MSOP clients come from the Department of Corrections through the civil commitment process after they have finished their period of incarceration. MSOP's mission is to promote public safety by providing sex offender treatment. Transfer, provisional discharge or discharge from MSOP must be ordered by the court.

SERVICES PROVIDED

We accomplish our mission by:

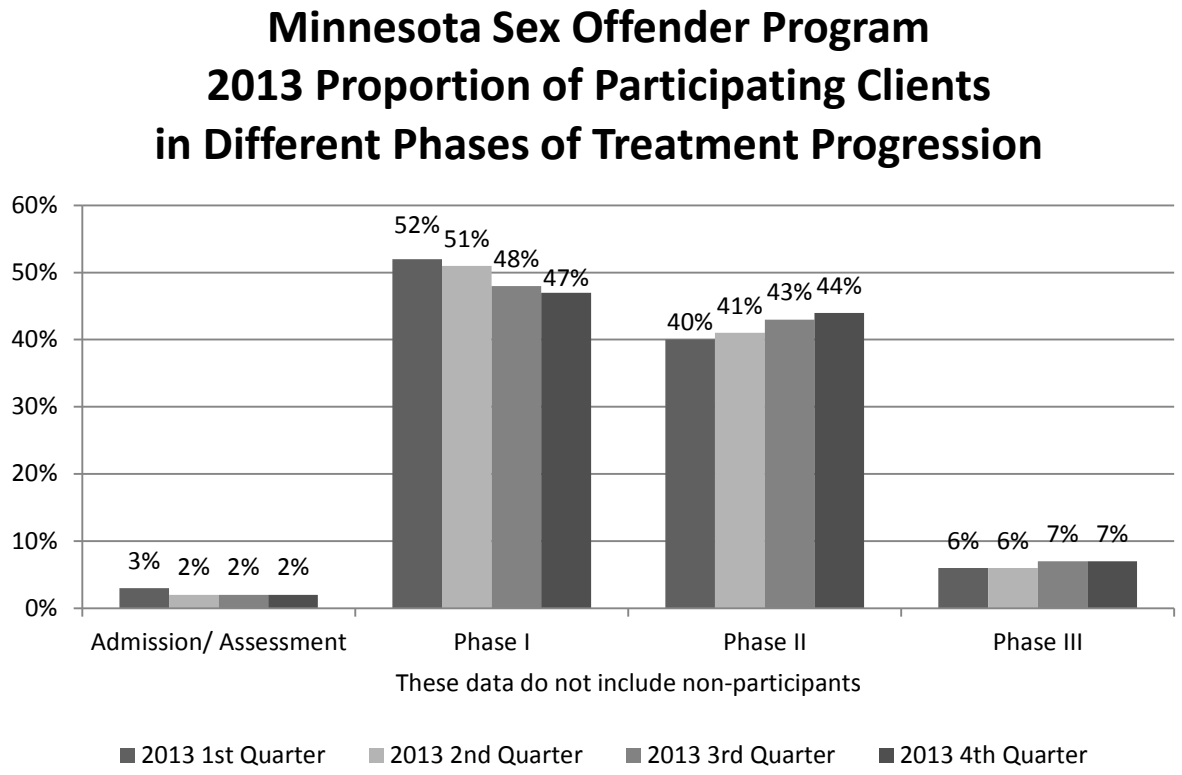
- Creating a therapeutic environment that is safe for clients and staff. The treatment model is client-centered and has a clear progression for each phase of treatment.
- Providing group therapy and opportunities to demonstrate meaningful change during three phases of treatment through participation in rehabilitative services, including education, therapeutic recreational activities and vocational work program assignments.
- Consulting with psychiatry services to ensure any medication interventions are available and appropriate to the clients we serve.
- Maximizing public safety by using technology to monitor client movement.
- Using our resources responsibly and efficiently.
- Working together with community, policy makers, and other governmental agencies.
- Developing resources for provisionally discharged clients to succeed in the community.

MSOP uses a three-phase treatment process. Clients initially address treatment-interfering behaviors and attitudes (Phase I) in preparation for focusing on their patterns of abuse and identifying and resolving the underlying issues in their offenses (Phase II). Clients in the later stages of treatment focus on deinstitutionalization and reintegration, applying the skills they acquired in treatment across settings and maintaining the changes they have made while managing their risk for re-offense (Phase III).

MSOP is funded by general fund appropriations. When a county commits someone to the program, the county is responsible for part of the cost of care. For commitments that happened before August 2011, the county share is ten percent. For commitments after that date, the county share is 25 percent.

RESULTS

As more clients move through the program, we expect to see increases in the number of clients participating in the latter stages of treatment. The chart below shows the treatment progression of clients over the past calendar year.



The legislature requires an annual performance report on the Minnesota Sex Offender Program. Two important measures in the performance report are the programwide per diem and client counts. For MSOP the programwide per diem is the calculated daily comprehensive cost of the program for each client.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Per diem	$317.00	$318.00	FY12 to FY14
Quantity	Increase in client population	653	697	FY12 to FY14

Results Notes

- Treatment progression graph is from the Minnesota Sex Offender Program Annual Performance Report 2013.
- Client population counts in the table are as of June 30th (the end of each fiscal year).
- The reported measure is the published per diem rate. It is the rate charged to counties when figuring a county's share of the cost of a client's care.

Minnesota Statutes, chapter 246B governs the operation of the Sex Offender Program and chapter 253D governs the civil commitment and treatment of sex offenders.

Program: Fiduciary Activities
Activity: Fiduciary Activities

AT A GLANCE

- In FY2013 roughly $650 million was collected and dispersed through this budget activity.
- Child Support program payments are the bulk of this activity, amounting to $620 million in the same year.
- All funds spending for the Fiduciary Activities activity for FY 2013 was $2.0 million. This represented 0.02% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The Fiduciary Activities budget program:

- Collects money from individuals and organizations (for example people who owe child support)
- Distributes the collected funds to people owed the money (such as children receiving child support)

Because these are not state funds and belong to others, they are not included in the state's budget or consolidated fund statement.

SERVICES PROVIDED

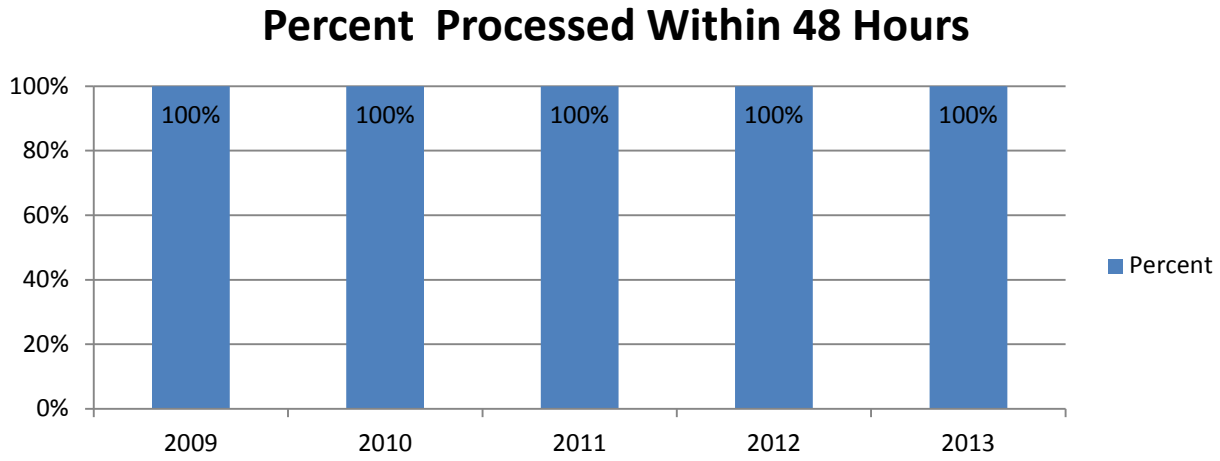
The following services make up most of the transactions of this budget activity:

- Child Support Payments: Payments made to custodial parents, collected from non-custodial parents
- Recoveries: Money recovered from clients that cannot be processed in the state computer systems. Funds are held here until they can be credited to the correct area, such as to:
  - US Treasury
  - Supplemental Security Income (SSI)
  - Counties
  - Clients
- Long Term Care Penalties: These are funds collected by the federal government (Centers for Medicare and Medicaid Services) related to penalties for nursing home violations. We use these to fund approved projects to improve nursing homes.

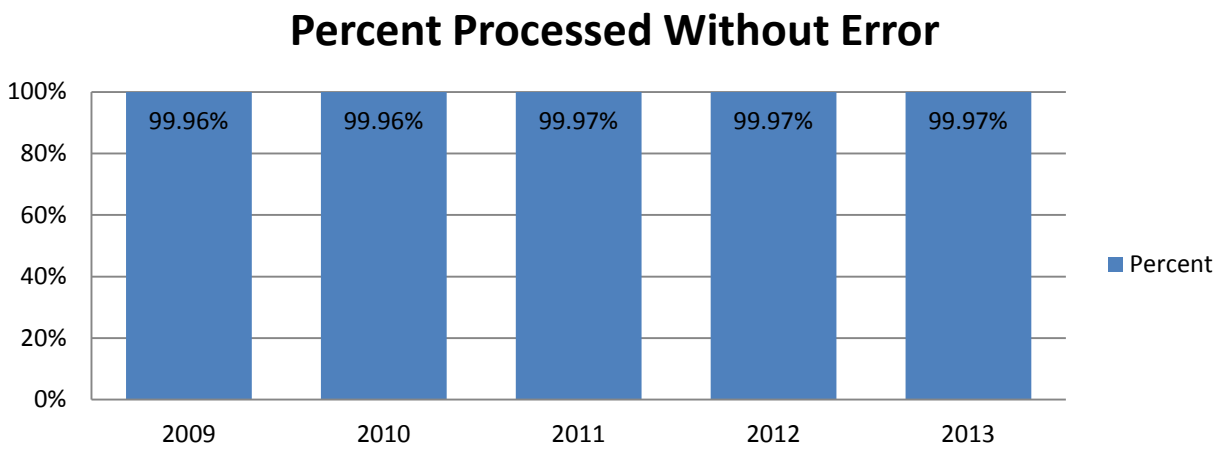
RESULTS

We provide clients with accurate, efficient, and timely payment processing.

Percent of Child Support Payments Processed within 48 Hours



Percent of Child Support Payments Processed without Errors



Several state statutes underlie the activities in the Fiduciary Activities budget program. These statutes are M.S. sections 256.741 (https://www.revisor.mn.gov/statutes/?id=256.741), 256.019 (https://www.revisor.mn.gov/statutes/?id=256.019), 256.01 (https://www.revisor.mn.gov/statutes/?id=256.01), and 256B.431 (https://www.revisor.mn.gov/statutes/?id=256B.431).

Program: Technical Activities
Activity: Technical Activities

AT A GLANCE

- Processes roughly $309 million each year in federal administrative reimbursement to counties, tribes and other local agencies.
- Processes and returns roughly $30 million each year in administrative reimbursements to the state Treasury.
- All funds spending for the Technical Activities activity for FY 2013 was $498.9 million. This represents 4.1% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The Technical Activities budget program includes transfers and expenditures between federal grants, programs and other agencies that would result in misleading distortions of the state's budget if the Department of Human Services did not account for them in a separate budget activity. This arrangement helps us to make sure that these transfers and expenditures are still properly processed in the state's accounting system and helps us comply with federal accounting requirements.

SERVICES PROVIDED

We include several different types of inter-fund and pass-through expenditures in the Technical Activities budget program:

- Federal administrative reimbursement earned by and paid to counties, tribes and other local agencies.
- Federal administrative reimbursement earned by and paid to other state agencies.
- Administrative reimbursement (primarily federal funds) earned on statewide indirect costs and paid to the general fund.
- Administrative reimbursement (primarily federal funds) earned on DHS Central Office administrative costs and paid to the general fund, health care access fund or special revenue fund under state law and policy.
- Transfers between federal grants, programs and state agencies that are accounted for as expenditures in the state's SWIFT accounting system.
- Other technical accounting transactions.

Staff members in our Operations Administration, which is part of our Central Office, are responsible for the accounting processes we use to manage the Technical Activities budget program.

RESULTS

We maintain necessary staff and information technology resources to adequately support accurate, efficient, and timely federal fund cash management. We measure the percentage of federal funds deposited within two working days.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	Percent of federal fund deposit transactions completed (deposited in State treasury) within two working days of the amount being identified by the SWIFT accounting system.	87%	94%	FY2012 to FY2013

M.S. sections 256.01 (https://www.revisor.mn.gov/statutes/?id=256.01)to 256.011 (https://www.revisor.mn.gov/statutes/?id=256.011) and Laws 1987, chapter 404, section 18, provide the overall state legal authority for DHS's Technical Activities budget program.